

6727

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY HAMPSHIRE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,				c. LENGTH OF STAY IN 1b 7 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First THOMAS Middle F. Last BARTLETT				4. DATE OF DEATH Month JULY Day 17 Year 1956			
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 25, 1875		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retire Cook - New Century Hotel		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Vince Bartlett				14. MOTHER'S MAIDEN NAME Kathleen Gales			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 236-12-1720		17. INFORMANT Memorial Hospital Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic nephritis with uremia 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Benign hyper trophy prostate							INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-10-56 , 19 56 , to 7-17-56 , 19 56 that I last saw the deceased alive on 7-16-56 , 19 56 , and that death occurred at 10:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Romney W. Va. DATE SIGNED 7-17-56							
ACTUAL SIGNATURE Howard L. Tolson		M.D. _____					
PHYSICIAN'S NAME (Type) HOWARD L. TOLSON							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial July 19, 1956		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Colored Cem.		22d. LOCATION (City, town, or county) (State) Romney W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Edith Shaffer		ADDRESS Romney W. Va.		24a. REC'D BY REGISTRAR DATE July 19, 1956		24b. REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WEST VIRGINIA

ROBERT

BARTLEY

WEST VIRGINIA

A. J. JONES

DEATH

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DEATH

BUREAU V. 8

JUL 20 1956

RECEIVED

6728

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 1/23/56		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary			e. STREET ADDRESS 514 Dilley Street		
3. NAME OF DECEASED (Type or print) First John Middle L. Last Becker			4. DATE OF DEATH Month July Day 21 Year 19 56		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/27/1879		9. AGE (In years lost birthday) 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired R. R. worker-Western Md.		10b. KIND OF BUSINESS OR INDUSTRY Cumberland, Maryland		10c. CITIZEN OF WHAT COUNTRY? U. S. E.	
13. FATHER'S NAME Louis Becker			14. MOTHER'S MAIDEN NAME Elizabeth Michaels		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT Allegany County Infirmary Records	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocardial degeneration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c) Pulmonary Hypostosis		INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **1/23/56**, 19**56**, to **7/21/56**, 19**56**, that I last saw the deceased alive on **7/21/56**, 19**56**, and that death occurred at **4:48P** M, from the causes and on the date stated above.

ACTUAL SIGNATURE **James E. McLean** M.D. ADDRESS (Street, city or town, state) **49 Greene St., Cumberland, Md.** DATE SIGNED **7/23/56**

PHYSICIAN'S NAME (Type) **Dr. James E. McLean**

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/25/56	22c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul	22d. LOCATION (City, town, or county) (State) Cumberland Md.
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		24a. REC'D BY REGISTRAR July 24, 1956	24b. REGISTRAR'S SIGNATURE W.R. Hantz M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06710

CERTIFICATE OF DEATH

Reg. Dist. No. 9

6782

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE MD.		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL or and give nearest town) Frostburg		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Nikep			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital				STREET ADDRESS (If rural give location) /			
3. NAME OF DECEASED (Type or Print) Emma Bostjancic				4. DATE OF DEATH (Month) (Day) (Year) 7/24/1956			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 4/2/1893	9. AGE last birthday 63 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work Own Home			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Lonaconing		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Arch Brown				14. MOTHER'S MAIDEN NAME Emma Beeman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Mrs. Lester Watkinson		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION (Daughter)		INTERVAL BETWEEN ONSET AND DEATH	
550.0 IMMEDIATE CAUSE (A) Uremia						4 days	
ANTECEDENT CAUSE(S) DUE TO (B) acute Congrenous Appendicitis						7 days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Diabetes Hypertension							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION July 21/1956		19b. MAJOR FINDINGS OF OPERATION acute Congrenous Appendicitis		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 20, 1956, to July 24, 1956, that I last saw the deceased alive on July 23, 1956, and that death occurred at 9:25 A.M. from the causes and on the date stated above.							
SIGNATURE W. B. Lane M.D.				ADDRESS (Street, city, town, state) Frostburg MD		DATE SIGNED July 27 1956	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 7/28/1956		NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		LOCATION (City, town, or county) (State) Moscow, MD.	
24. REC'D BY REGISTRAR DATE 7-26-56		REGISTRAR'S SIGNATURE Wm. Nauley N. Roe		25. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, MD.			

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6729

CERTIFICATE OF DEATH

06711

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland (Inside City Limits)			c. LENGTH OF STAY IN 1b 10 years		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Willowbrook Road			d. STREET ADDRESS Willowbrook Road		
3. NAME OF DECEASED (Type or print) First Ida Middle Belle Last Bible			4. DATE OF DEATH Month July Day 13 Year 1956		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17, 1871		9. AGE (In years last birthday) 85 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME John Morral			14. MOTHER'S MAIDEN NAME Rebecca Dean		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Melvin Bible Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from July 13, 1956 to July 13, 1956 that I last saw the deceased alive on July 13, 1956 , and that death occurred at 7:40 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE W. T. Johnson		M.D. Cumberland, Md.		DATE SIGNED 7-16-56	
PHYSICIAN'S NAME (Type) W. T. Johnson, M.D., James T. Johnson, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/16/56		22c. NAME OF CEMETERY OR CREMATORY Bible Cemetery	
				22d. LOCATION (City, town, or county) (State) Flintstone, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox			ADDRESS Cumberland, Md.		
24a. REC'D BY REGISTRAR July 16, 1956			24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.		

CERTIFICATE OF DEATH

0729

BUREAU V. 8

JUL 18 1956

RECEIVED

DR. R. J. WMS. 6730

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 1 DAY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First MARGARET Middle BITTINGER Last BITTINGER		4. DATE OF DEATH Month JULY Day 14 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 5, 1873
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR: Months 83 Days 83 Hours 83 Min. 83	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME CHARLES WARNICK		14. MOTHER'S MAIDEN NAME MARTHA FAZENBAKER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MEMORIAL HOSPITAL-MEMORIAL-MEMORIAL & WARWICK AVE		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs not known	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/13/56 19, to 7/14/56 19, that I last saw the deceased alive on 7/14/56 19, and that death occurred at 5:58 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland DATE SIGNED 7/14/56 ACTUAL SIGNATURE B. J. Williams M.D. PHYSICIAN'S NAME (Type) B. J. WILLIAMS, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-17-56	
22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		22d. LOCATION (City, town, or county) (State) Moscow, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Edw. S. Boac		ADDRESS Weston Park, Md.	
24a. REC'D BY REGISTRAR July 16, 1956		24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

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BUREAU V. 8

1956 18 JUL

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

6731

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W.Va. b. COUNTY Mineral	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 14 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Monroe Last Bower		4. DATE OF DEATH Month July Day 3 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24-1936
9. AGE (In years last birthday) 20 yrs.		IF UNDER 1 YEAR Months 20 Days 3	IF UNDER 24 HRS. Hours 19 Min. 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Apprentice, Millwright		10b. KIND OF BUSINESS OR INDUSTRY Hinkle Bros.	
11. BIRTHPLACE (State or foreign country) Morgantown, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harley Bower		14. MOTHER'S MAIDEN NAME Donna Stull	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 235-52-2955	
17. INFORMANT Memorial Hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia 916.3 DUE TO 1st. 2nd. & 3rd. degree burns of body Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Gas leak, explosion & flash fire. INTERVAL BETWEEN ONSET AND DEATH 14 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Plate & Glass Plant.			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. Gas leak, explosion & flash fire at the new Pittsburgh		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) North Branch near	
20c. TIME OF INJURY Month, Day, Year 7.30 a.m. 6-19 1956		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> Pitt. P & G Plant Cumberland, Allegany, Md.	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) North Branch near		20f. (City or town) (County) (State) Pitt. P & G Plant Cumberland, Allegany, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H.V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 3-1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 6, 1956	
22c. NAME OF CEMETERY OR CREMATORY Morgantown Cemetery		22d. LOCATION (City, town, or county) (State) Morgantown, West Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred L. Jenkins Funeral Home, Morgantown,		24a. REC'D BY REGISTRAR July 6, 1956	
		24b. REGISTRAR'S SIGNATURE H.V. Deming M.D.	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUL 9 1956
BUREAU V. B.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Joseph Last Brant		4. DATE OF DEATH Month July Day 27 Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 14-1899
9. AGE (In years last birthday) 56 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Norman Brant		14. MOTHER'S MAIDEN NAME Veletta Pitzer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Memorial Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic lymphatic leukemia DUE TO 204.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Retroperitoneal hemorrhage (c) Enlarged spleen Petechia of lungs.		INTERVAL BETWEEN ONSET AND DEATH 4 yrs 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H.V. Deming M.D.		DATE SIGNED	
EXAMINER'S NAME (Type) H.V. Deming M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 27-1956	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF July 29, 1956	
22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Light		24. REC'D BY REGISTRAR July 29, 1956	
ADDRESS Cumberland, Md.		24b. REGISTRAR'S SIGNATURE H.R. Frantz, M.D.	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John Joseph	
Residence		Boston, Mass.	
Age		35	
Sex		Male	
Race		White	
Religion		None	
Marital Status		Married	
Cause of Death		Chronic Myocardial Infarction	
Manner of Death		Natural	
Date of Death		July 31, 1956	
Time of Death		About 3:00 PM	
Signature of Medical Examiner		[Signature]	
Signature of Coroner		[Signature]	

BUREAU V. 2

JUL 31 1956

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nikep		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nikep	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In garage at home.		d. STREET ADDRESS Box 181 Barton, Md.	
3. NAME OF DECEASED (Type or print) First Middle Last Bertha R. Broadwater		4. DATE OF DEATH Month Day Year July 27 19 56	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19-1892
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY (rural) Garrett, Co.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Green		14. MOTHER'S MAIDEN NAME Anna Winebrener	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT (son) Forest Broadwater, Nikep, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to strangulation by Hanging DUE TO (b) about 5 min. Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hung herself in garage by strips of muslin.			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 3:30 p. m. July 27 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home, in garage		20f. (City or town) (County) (State) Nikep, Allegany Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H. V. Deming M.D.		DATE SIGNED	
EXAMINER'S NAME (Type) H. V. Deming M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 27-1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-30-56	22c. NAME OF CEMETERY OR CREMATORY Laurel Hill	22d. LOCATION (City, town, or county) (State) Moscow, Md.
23. REGISTRATION SIGNATURE *****		24a. REC'D BY REGISTRAR 7/28/56	24b. REGISTRAR'S SIGNATURE James M. Boal

NEWMAN FUNERAL HOME, GRANSVILLE, MD.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF MEDICAL EXAMINING CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
John J. Barton		45		Male		White	
Place of Birth		Date of Birth		Date of Death		Time of Death	
New York City		March 10, 1905		March 10, 1956		10:30 A.M.	
Usual Residence		Cause of Death		Manner of Death		Occupation	
100 West 100th St., New York City		Coronary Artery Disease		Natural		None	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Signature		Date of Signature		Date of Signature		Date of Signature	
March 10, 1956		March 10, 1956		March 10, 1956		March 10, 1956	

BUREAU V. 4

AUG 3 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06716

6793

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt. 1, Frostburg</u>		c. LENGTH OF STAY IN 1b <u>life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt. 1, Frostburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>REBECCA</u> Middle <u>JANE</u> Last <u>BRODE</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>11</u> Year <u>19 56</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-15-1895</u>		9. AGE (In years last birthday) yrs. <u>61</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. H. Barnes</u>				14. MOTHER'S MAIDEN NAME <u>Ellen J. Loar</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Albert Ritchie, Rt. 1, Frostburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA of is - TRANSVERSE Colon</u> 153x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>AUG. 1955</u> to <u>July 11, 1956</u> , that I last saw the deceased alive on <u>July 9, 1956</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John C. Devers</u> M.D.			ADDRESS (Street, city or town, state) <u>Frostburg, Md.</u>			DATE SIGNED <u>7/11/56</u>	
PHYSICIAN'S NAME (Type) <u>John C. Devers</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-13-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst,</u>				ADDRESS <u>Frostburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>7-13-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Willie Nancy N. RAE</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 68	
4. DATE OF DEATH July 15, 1956		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. SIGNATURE OF PHYSICIAN J. H. Harris	
10. SIGNATURE OF REGISTRAR J. H. Harris		11. SIGNATURE OF WITNESSES J. H. Harris		12. SIGNATURE OF DECEASED J. H. Harris	
13. SIGNATURE OF DECEASED J. H. Harris		14. SIGNATURE OF DECEASED J. H. Harris		15. SIGNATURE OF DECEASED J. H. Harris	
16. SIGNATURE OF DECEASED J. H. Harris		17. SIGNATURE OF DECEASED J. H. Harris		18. SIGNATURE OF DECEASED J. H. Harris	
19. SIGNATURE OF DECEASED J. H. Harris		20. SIGNATURE OF DECEASED J. H. Harris		21. SIGNATURE OF DECEASED J. H. Harris	
22. SIGNATURE OF DECEASED J. H. Harris		23. SIGNATURE OF DECEASED J. H. Harris		24. SIGNATURE OF DECEASED J. H. Harris	
25. SIGNATURE OF DECEASED J. H. Harris		26. SIGNATURE OF DECEASED J. H. Harris		27. SIGNATURE OF DECEASED J. H. Harris	
28. SIGNATURE OF DECEASED J. H. Harris		29. SIGNATURE OF DECEASED J. H. Harris		30. SIGNATURE OF DECEASED J. H. Harris	
31. SIGNATURE OF DECEASED J. H. Harris		32. SIGNATURE OF DECEASED J. H. Harris		33. SIGNATURE OF DECEASED J. H. Harris	
34. SIGNATURE OF DECEASED J. H. Harris		35. SIGNATURE OF DECEASED J. H. Harris		36. SIGNATURE OF DECEASED J. H. Harris	
37. SIGNATURE OF DECEASED J. H. Harris		38. SIGNATURE OF DECEASED J. H. Harris		39. SIGNATURE OF DECEASED J. H. Harris	
40. SIGNATURE OF DECEASED J. H. Harris		41. SIGNATURE OF DECEASED J. H. Harris		42. SIGNATURE OF DECEASED J. H. Harris	
43. SIGNATURE OF DECEASED J. H. Harris		44. SIGNATURE OF DECEASED J. H. Harris		45. SIGNATURE OF DECEASED J. H. Harris	
46. SIGNATURE OF DECEASED J. H. Harris		47. SIGNATURE OF DECEASED J. H. Harris		48. SIGNATURE OF DECEASED J. H. Harris	
49. SIGNATURE OF DECEASED J. H. Harris		50. SIGNATURE OF DECEASED J. H. Harris		51. SIGNATURE OF DECEASED J. H. Harris	
52. SIGNATURE OF DECEASED J. H. Harris		53. SIGNATURE OF DECEASED J. H. Harris		54. SIGNATURE OF DECEASED J. H. Harris	
55. SIGNATURE OF DECEASED J. H. Harris		56. SIGNATURE OF DECEASED J. H. Harris		57. SIGNATURE OF DECEASED J. H. Harris	
58. SIGNATURE OF DECEASED J. H. Harris		59. SIGNATURE OF DECEASED J. H. Harris		60. SIGNATURE OF DECEASED J. H. Harris	
61. SIGNATURE OF DECEASED J. H. Harris		62. SIGNATURE OF DECEASED J. H. Harris		63. SIGNATURE OF DECEASED J. H. Harris	
64. SIGNATURE OF DECEASED J. H. Harris		65. SIGNATURE OF DECEASED J. H. Harris		66. SIGNATURE OF DECEASED J. H. Harris	
67. SIGNATURE OF DECEASED J. H. Harris		68. SIGNATURE OF DECEASED J. H. Harris		69. SIGNATURE OF DECEASED J. H. Harris	
70. SIGNATURE OF DECEASED J. H. Harris		71. SIGNATURE OF DECEASED J. H. Harris		72. SIGNATURE OF DECEASED J. H. Harris	
73. SIGNATURE OF DECEASED J. H. Harris		74. SIGNATURE OF DECEASED J. H. Harris		75. SIGNATURE OF DECEASED J. H. Harris	
76. SIGNATURE OF DECEASED J. H. Harris		77. SIGNATURE OF DECEASED J. H. Harris		78. SIGNATURE OF DECEASED J. H. Harris	
79. SIGNATURE OF DECEASED J. H. Harris		80. SIGNATURE OF DECEASED J. H. Harris		81. SIGNATURE OF DECEASED J. H. Harris	
82. SIGNATURE OF DECEASED J. H. Harris		83. SIGNATURE OF DECEASED J. H. Harris		84. SIGNATURE OF DECEASED J. H. Harris	
85. SIGNATURE OF DECEASED J. H. Harris		86. SIGNATURE OF DECEASED J. H. Harris		87. SIGNATURE OF DECEASED J. H. Harris	
88. SIGNATURE OF DECEASED J. H. Harris		89. SIGNATURE OF DECEASED J. H. Harris		90. SIGNATURE OF DECEASED J. H. Harris	
91. SIGNATURE OF DECEASED J. H. Harris		92. SIGNATURE OF DECEASED J. H. Harris		93. SIGNATURE OF DECEASED J. H. Harris	
94. SIGNATURE OF DECEASED J. H. Harris		95. SIGNATURE OF DECEASED J. H. Harris		96. SIGNATURE OF DECEASED J. H. Harris	
97. SIGNATURE OF DECEASED J. H. Harris		98. SIGNATURE OF DECEASED J. H. Harris		99. SIGNATURE OF DECEASED J. H. Harris	
100. SIGNATURE OF DECEASED J. H. Harris		101. SIGNATURE OF DECEASED J. H. Harris		102. SIGNATURE OF DECEASED J. H. Harris	

RECEIVED
JUL 16 1956
BUREAU V. 8

With In Corporate Limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06717

6733

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY Allegany MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) Cumberland TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Allegany CITY (If outside corporate limits, write RURAL and give nearest town) Cumberland TOWN STREET ADDRESS (If rural give location) 315 Maryland Avenue			
3. NAME OF DECEASED (Type or Print) Oscar Earl Burkett (First) (Middle) (Last)			4. DATE OF DEATH July 12, 1956 (Month) (Day) (Year)				
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH 3/30/1894	9. AGE last birthday 62 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipefitter- Celanese Corp.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ellerslie, Maryland			
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME William Harvey Burkett			14. MOTHER'S MAIDEN NAME Deborah Elliott				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-07-0246		17. INFORMANT & ADDRESS Allegany County Infirmary Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage ANTECEDENT CAUSE(S) DUE TO (B) Cerebral Arteriosclerosis DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Chronic Myocarditis Chronic Nephritis				18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs. ? ? ?			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) 2/25/1955		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2/25/1955 to 7/12/1956 , that I last saw the deceased alive on 7/12/1956 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.							
SIGNATURE Dr. James E. McLean		ADDRESS (Street, city, town, state) 49 Greene St., Cumberland, Md.		DATE SIGNED 7/13/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7/15/56		NAME OF CEMETERY OR CREMATORY Greenmount Cemetery			
24. REC'D BY REGISTRAR July 15, 1956		REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George			
				ADDRESS Cumberland, Md.			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

CERTIFICATE OF DEATH

6738

1. NAME OF DEATH		2. SEX	
Allegany		Male	
3. AGE		4. DATE OF BIRTH	
24/2/22		3/31/1891	
5. PLACE OF BIRTH		6. OCCUPATION	
Cumberland		Farmer	
7. COUNTY		8. CITY	
Allegany County		Martinsburg	
9. STREET		10. STATE	
312 Maryland Avenue		Maryland	
11. DATE OF DEATH		12. TIME OF DEATH	
July 15, 1956		10:30 AM	
13. CAUSE OF DEATH		14. MANNER OF DEATH	
Disease		Natural	
15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF WITNESSES	
William Harvey Burkett		James E. Nelson	
17. SIGNATURE OF DEATH REGISTRAR		18. SIGNATURE OF CORONER	
Allegany County Infirmary Records		James E. Nelson	
19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF BURIAL PLACE	
Allegany County Infirmary Records		Allegany County Infirmary Records	
21. SIGNATURE OF BURIAL PLACE		22. SIGNATURE OF BURIAL PLACE	
Allegany County Infirmary Records		Allegany County Infirmary Records	
23. SIGNATURE OF BURIAL PLACE		24. SIGNATURE OF BURIAL PLACE	
Allegany County Infirmary Records		Allegany County Infirmary Records	
25. SIGNATURE OF BURIAL PLACE		26. SIGNATURE OF BURIAL PLACE	
Allegany County Infirmary Records		Allegany County Infirmary Records	
27. SIGNATURE OF BURIAL PLACE		28. SIGNATURE OF BURIAL PLACE	
Allegany County Infirmary Records		Allegany County Infirmary Records	
29. SIGNATURE OF BURIAL PLACE		30. SIGNATURE OF BURIAL PLACE	
Allegany County Infirmary Records		Allegany County Infirmary Records	
31. SIGNATURE OF BURIAL PLACE		32. SIGNATURE OF BURIAL PLACE	
Allegany County Infirmary Records		Allegany County Infirmary Records	
33. SIGNATURE OF BURIAL PLACE		34. SIGNATURE OF BURIAL PLACE	
Allegany County Infirmary Records		Allegany County Infirmary Records	
35. SIGNATURE OF BURIAL PLACE		36. SIGNATURE OF BURIAL PLACE	
Allegany County Infirmary Records		Allegany County Infirmary Records	
37. SIGNATURE OF BURIAL PLACE		38. SIGNATURE OF BURIAL PLACE	
Allegany County Infirmary Records		Allegany County Infirmary Records	
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JUL 18 1956
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06718

6734

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE Maryland		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Cumberland		LENGTH OF STAY (in this place) 11/23/53		CITY (If outside corporate limits, write RURAL and give nearest town) Cumberland		TOWN Cumberland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary				STREET ADDRESS (If rural give location) 232 N. Centre Street			
3. NAME OF DECEASED (First) (Middle) (Last) Mabel L. Byrd				4. DATE OF DEATH (Month) (Day) (Year) July 10, 1956			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH 6/8/1894	9. AGE last birthday 62 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Upper Track, Pennsylvania (Pendleton County)		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Solon K. Lantz				14. MOTHER'S MAIDEN NAME Mary Alice Teter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 220-10-9367		17. INFORMANT & ADDRESS Allegany County Infirmary Records			

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A) Chronic Myocarditis						?	
ANTECEDENT CAUSE(S) DUE TO						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) General arteriosclerosis		?	
				(C) Secondary anemia		?	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				Arthritis Deformans		?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from 11/23 / 1953 to 7/10 / 1956 that I last saw the deceased alive on 7/10 / 1956 and that death occurred at 2:45 P.M. from the causes and on the date stated above.			
SIGNATURE Dr. James E. McLean		DATE SIGNED 7/10/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF July 13, 1956	
NAME OF CEMETERY OR CREMATORY Cedar Hill Cem		LOCATION (City, town, or county) (State) Franklin, West Virginia	
24. REC'D BY REGISTRAR July 12, 1956		25. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md	

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

6734

May 1956

1. Name of deceased (Print or write)

Allegany County, Maryland

Allegany

Allegany

Obituary

Obituary

Obituary

325 E. Centre Street

Allegany County, Maryland

July 10, 1956

Male

1.

Male

62

6/8/1894

Widow

Female White

United States, Pennsylvania, N. S. A.

Honolulu

Mary Alice Foster

Robert E. Foster

Allegany County, Maryland

Allegany County, Maryland

Allegany County, Maryland

Allegany County, Maryland

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BUREAU V. 1

JUL 16 1956

RECEIVED

JUL 10 1956

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JUL 10 1956

JUL 10 1956

6735

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 6 HRS 45 MINS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 613 1/2 LOUISIANA AVENUE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First BERTHA Middle L. Last CARNEY				4. DATE OF DEATH Month 7 Day 5 Year 19 56			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 17 1886	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY House Wife			
11. BIRTHPLACE (State or foreign country) W.VA.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME L.SAMPLE JOHNSON				14. MOTHER'S MAIDEN NAME MARY SWEARENGIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Address MEMORIAL HOSPITAL MEMORIAL AVENUE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hypertensive Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) disease DUE TO (c) disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 Hours							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 5, 1956 to 7-5-56 that I last saw the deceased alive on 7-5-56 and that death occurred at 11:25 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm. F. Williams M.D.				ADDRESS (Street, city or town, state) Cumberland Md			
DATE SIGNED 7-6-56							
PHYSICIAN'S NAME (Type) DR. W.F.WMS.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 7 1956		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. F. Williams				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE July 6, 1956	
24b. REGISTRAR'S SIGNATURE W.R. Frantz, M.D.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

1956 6 JUL

RECEIVED
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6736 **CERTIFICATE OF DEATH**Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		STATE Maryland		COUNTY Allegany			
CITY (If outside corporate limits, write RURAL and give nearest town) Cumberland		LENGTH OF STAY (In this place) 12/7/53		CITY (If outside corporate limits, write RURAL and give nearest town) Cumberland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary				STREET ADDRESS (If rural give location) 438 Goethe Street			
3. NAME OF DECEASED				4. DATE OF DEATH			
(First) Mary		(Middle) C.		(Last) Claar		(Month) (Day) (Year) July 31, 1956	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 8/15/1866	9. AGE last birthday 89 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Samuel Sellers				14. MOTHER'S MAIDEN NAME Rebecca Mower			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS P. O. Box 599 Allegany County Infirmary Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) Pulmonary Hypostasis				INTERVAL BETWEEN ONSET AND DEATH 36 hrs			
ANTECEDENT CAUSE(S) DUE TO Chronic Myocarditis				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO General Arteriosclerosis				?			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Nephritis				?			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12/7/53, 19 to 7/31/56, 19, that I last saw the deceased alive on 7/31/56, 19, and that death occurred at 2:30 P.M. from the causes and on the date stated above.							
SIGNATURE Dr. James E. McLean				DATE SIGNED 8/1/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. REC'D BY REGISTRAR Aug 2, 1956		REGISTRAR'S SIGNATURE Walter R. Frank, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845. 8

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REGISTRATION

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CERTIFICATE OF DEATH

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Reg. Dist. No.

6783

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| 1. PLACE OF DEATH
o. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Md.</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u> | | | |
| c. LENGTH OF STAY IN 1b <u>Lifetime</u> | | | | d. STREET ADDRESS <u>78 Mt. Pleasant St.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>78 Mt. Pleasant Street</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Annie Connelley</u> | | | | 4. DATE OF DEATH Month Day Year <u>7 8th 19 56.</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8 - 21 - 1870</u> | |
| | | | | 9. AGE (In years last birthday) <u>85</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Hoffman, Md.</u> | |
| 13. FATHER'S NAME <u>Henry Metzner</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Ellen Moody</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u> | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | | |
| 17. INFORMANT <u>James Henry Connelley</u> | | | | Address <u>114 Mt. Pleasant St. Frostburg, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myoplasm of Colon</u> DUE TO <u>153X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>Two weeks</u>
(c) <u>153X</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Quarantined prior to death. Chronic Myocarditis</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21. I certify that I attended the deceased from <u>5-27-56</u> to <u>7-8-56</u> , that I last saw the deceased alive on <u>7-5-56</u> , 19 <u>56</u> , and that death occurred at <u>3 P. M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>J. T. Johnson</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Cumberland Md</u> | | | |
| DATE SIGNED <u>7-10-56</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>James T. Johnson Jr. Md.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>7-11-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Frostburg Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Benedict H. Montanari</u> ADDRESS <u>HAFFER FUNERAL HOME 3 E. Main, Frostburg, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE 7-11-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Willie Nancy N. Rae</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|--|--|---|--|
| <p>1. Name of deceased: <i>John A. Smith</i></p> | | <p>2. Sex: <i>Male</i></p> | |
| <p>3. Date of birth: <i>Jan 15, 1890</i></p> | | <p>4. Place of birth: <i>St. Louis, Mo.</i></p> | |
| <p>5. Date of death: <i>Jul 10, 1956</i></p> | | <p>6. Place of death: <i>Home</i></p> | |
| <p>7. Cause of death: <i>Heart Disease</i></p> | | <p>8. Immediate cause: <i>Myocardial Infarction</i></p> | |
| <p>9. Duration of illness: <i>2 weeks</i></p> | | <p>10. Usual place of abode: <i>Home</i></p> | |
| <p>11. Name of attending physician: <i>Dr. J. H. Jones</i></p> | | <p>12. Name of medical examiner: <i>Dr. A. B. Brown</i></p> | |
| <p>13. Name of funeral home: <i>Smith & Sons</i></p> | | <p>14. Name of cemetery: <i>Greenwood</i></p> | |
| <p>15. Name of informant: <i>John A. Smith</i></p> | | <p>16. Signature of informant: <i>[Signature]</i></p> | |
| <p>17. Name of registrar: <i>John A. Smith</i></p> | | <p>18. Signature of registrar: <i>[Signature]</i></p> | |

BUREAU V. S.

JUL 16 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 and 5 should be retained by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06722

Reg. Dist. No. 4

6737

| | | | | | |
|--|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH
o. COUNTY <u>Allegany</u> <u>MARYLAND</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Md.</u> b. COUNTY <u>Allegany</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | c. LENGTH OF STAY IN lb
<u>14 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Memorial Hospital</u> | | | d. STREET ADDRESS
<u>946 Gay St.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>Sherman</u> <u>Warfield</u> <u>Crabtree</u> | | | 4. DATE OF DEATH Month Day Year
<u>July</u> <u>19</u> <u>19 56</u> | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>June 24-1898</u> | 9. AGE (In years last birthday)
<u>58</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Trackman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>B& O.R.Ry.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Old Town, Md.</u> | |
| 13. FATHER'S NAME
<u>Michael Crabtree</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Edna J. Twigg</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO.
<u>214-05-9630</u> | | 17. INFORMANT Address
<u>Memorial Hospital Records.</u> | |

| | | | | | | |
|---|---|--|---------------------|--|---|----------------------------------|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary embolism(massive)</u> about <u>6 Hrs.</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Post-operative cystolithectomy</u> <u>10 days</u>
(a), stating the underlying cause lost. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | |
| ACTUAL SIGNATURE <u>H. V. Doring M.D.</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | | |
| EXAMINER'S NAME (Type) <u>H. V. Doring M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>July 19-1956</u> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>7/21/56</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Bethel Methodist Cem</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Bedford County, Pennsylvania</u> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>John J. Hafer, Cumberland, Maryland</u> | | ADDRESS
<u>Hafer</u> | | 24. REC'D BY REGISTRAR
<u>July 21, 1956</u> | 24b. REGISTRAR'S SIGNATURE
<u>W. R. Frantz, M.D.</u> | |

NEW YORK STATE DEPARTMENT OF HEALTH - BALTICORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 24 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06723

Reg. Dist. No. 4

6738

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE WEST VIRGINIA b. COUNTY GRANT | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PETERSBURG | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First SARAH Middle DANZENBAKER Last DANZENBAKER | | | | 4. DATE OF DEATH
Month JULY Day 21 Year 1956 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
JUNE 29, 1890 | |
| 9. AGE (In years last birthday) 66 yrs. | | IF UNDER 1 YEAR
Months 66 Days 66 Hours 66 Min. 66 | | IF UNDER 24 HRS.
Months 66 Days 66 Hours 66 Min. 66 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME DOUGLAS SOMMERVILLE | | | | 14. MOTHER'S MAIDEN NAME MARGARET WALKER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT Address MEMORIAL HOSPITAL | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1. Terminal Cardiac Failure
443X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2. Hypertensive Cardiovascular disease DUE TO
(c) 2 years. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 month |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5 July, 1956 , to 21 July, 1956 , that I last saw the deceased alive on 21 July, 1956 , and that death occurred at 7:40 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE W. Alfred Van Ormer | | M.D. Cumberland, Md. | | ADDRESS (Street, city or town, state) | | DATE SIGNED 23 July 56 | |
| PHYSICIAN'S NAME (Type) W A VAN ORMER, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF July 24, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY Maple Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Petersburg, West Virginia. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Schaeffer Funeral Home, Petersburg, West Virginia | | | | 24a. REC'D BY REGISTRAR DATE July 23, 1956 | | 24b. REGISTRAR'S SIGNATURE W. H. Frank M.D. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATISTICAL INFERENCE

BUREAU V. 2

JUL 24 1956

RECEIVED

1. Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06724

CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

| | | | | | | | |
|--|----------------------------|--|---|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Cumberland</u> | | <u>4yr.2mo.21da.</u> | | TOWN <u>Westernport</u> | | <u>43</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Retreat, Furnace St.</u> | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Nettie Anna Dawson</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>July 24 1956</u> | | | |
| 5. SEX <u>F.</u> | 6. COLOR OR RACE <u>W.</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W.</u> | 8. DATE OF BIRTH <u>Aug. 10, 1870</u> | 9. AGE last birthday <u>85</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| | | | | | Months | Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | 11. BIRTHPLACE (State or foreign country) <u>Clarkburg, West Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James O. Ross</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Margaret Guy</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS <u>Mrs. Hazel Fledge Corriganville Md</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| 592X IMMEDIATE CAUSE (A) | | | | <u>Chronic Myocarditis</u> | | <u>?</u> | |
| ANTECEDENT CAUSE(S) DUE TO | | | | <u>Cerebral arteriosclerosis</u> | | <u>?</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | <u>Chronic Hepatitis</u> | | <u>?</u> | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | <u>Smile psychosis</u> | | <u>4 yrs. +</u> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>May 3, 1952</u> to <u>July 24, 1956</u> , that I last saw the deceased alive on <u>July 23, 1956</u> , and that death occurred at <u>8:15 a.m.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>James B. DeLeon</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>49 Greene St.</u> | | DATE SIGNED <u>7-24-56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>7/27/56</u> | | <u>Philos Cem</u> | | <u>Westernport Md</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>July 26, 1956</u> | | <u>Walter R. Frantz, M.D.</u> | | <u>E. J. Boral</u> | | <u>Westernport, Md</u> | |

VS AISC 1-55 10M

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

REGISTRATION NUMBER

1. NAME OF DECEASED

2. PLACE OF BIRTH

3. SEX

4. AGE

5. DATE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERGYMAN

14. SIGNATURE OF OTHER

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BUREAU V. 1. 81

1956 27 1956

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RECEIVED

06725

6794 CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|--|----------------------------------|--|--|---|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)
TOWN <u>Cumberland</u> | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN <u>Cumberland</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rt. 6, Narrows Park</u> | | | | STREET ADDRESS (If rural give location)
<u>Rt. 6, Narrows Park</u> | | | |
| 3. NAME OF DECEASED
(Type or Print) <u>MAUDE</u> <u>ESTELLA</u> <u>DEREMER</u> | | | | 4. DATE OF DEATH
(Month) <u>July</u> (Day) <u>16</u> (Year) <u>19 56</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u> | 8. DATE OF BIRTH
<u>Dec. 26, 1875</u> | 9. AGE last birthday
<u>80</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Coartown, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Holland Bane</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Rebecca Loar</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT & ADDRESS
<u>Rt. 6</u>
<u>Marshall Deremer, Cumberland, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| 420.0 IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u> | | | | | | <u>3 days</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. <input type="checkbox"/> P. <input type="checkbox"/>) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Nov. 19, 1955</u> , to <u>July 16, 1956</u> , that I last saw the deceased alive on <u>14th July, 1956</u> , and that death occurred at <u>12:05 P.M.</u> , from the causes and on the date stated above.
SIGNATURE <u>William R. James</u> M.D. <u>441 N. Centre St., Cumberland, Md.</u> DATE SIGNED <u>7-17-56</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | DATE THEREOF
<u>7/16/56</u> | | NAME OF CEMETERY OR CREMATORY
<u>Rose Hill Cemetery</u> | | LOCATION (City, town, or county) (State)
<u>Cumberland, Maryland</u> | |
| 24. REC'D BY REGISTRAR
<u>July 18, 1956</u> | | REGISTRAR'S SIGNATURE
<u>Winters R. Frantz, M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>John J. Hafer, Cumberland, Maryland</u> | | | |

INSTRUCTIONS

TO A ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. The bottom copy may be retained by the attending physician and completely filled in by the funeral director, the third copy of death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06726

CERTIFICATE OF DEATH

Reg. Dist. No. 9

6784

| | | | | | | | |
|--|----------------------------------|--|--|---|--------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Allegany | | STATE MARYLAND | | STATE MD | | COUNTY Allegany | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)
Frostburg | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town)
Frostburg, R.F.D. # 1 | | TOWN | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
Miners Hospital | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) Daniel | | (Middle) | | (Last) De Vault | | (Month) (Day) (Year)
7/23.1956 19 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
Single | 8. DATE OF BIRTH
May 9th. 1938 | 9. AGE last birthday
18 yrs. | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
School Student | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
National, MD | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Charles De Vault | | | | 14. MOTHER'S MAIDEN NAME
Ida Mae Beeman | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT & ADDRESS
Charles De Vault, (FATHER) | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION
Frostburg MD. | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (A) 401.0 Congestive heart failure | | | | | | 24 hrs. | |
| ANTECEDENT CAUSE(S) DUE TO (B) Aplastic anemia | | | | | | 5 days | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Rheumatic fever | | | | | | 4 mos. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from May 28, 1956 , to July 23, 1956 , that I last saw the deceased alive on July 23, 1956 , and that death occurred at 7 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
Leslie R. Miller Jr. | | M.D. | | ADDRESS (Street, city, town, State)
Lonaconing Md. | | DATE SIGNED
July 25, 1956 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | DATE THEREOF
7/26/1956 | | NAME OF CEMETERY OR CREMATORY
Memorial Park | | LOCATION (City, town, or county) (State)
Frostburg, MD. | |
| 24. REC'D BY REGISTRAR
DATE 7-26-56 | | REGISTRAR'S SIGNATURE
Mrs. Nancy A. Roe | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
George Eichhorn, Lonaconing, MD. | | | |

CERTIFICATE OF DEATH

6738

1. NAME OF DECEASED

Alfred

Alfred

Residence

1111 N. E. Street

City

Deceased

Age

75

Sex

Male

Married

Occupation

Charles D. Smith

Residence

1111 N. E. Street

Time

11:00 A.M.

Place

Home

BUREAU V. 1

JUL 31 1956

RECEIVED

6740

CERTIFICATE OF DEATH

Reg. Dist. No.

4

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | | c. LENGTH OF STAY IN lb
9 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Memorial Hospital, Memorial Ave. | | | | d. STREET ADDRESS
105 Poplar St. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Mrs. Laura De Witt | | | | 4. DATE OF DEATH
Month July Day 29 Year 19 56 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Nov. 28, 1867 | |
| 9. AGE (In years last birthday)
88 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Elisa Merrill | | | | 14. MOTHER'S MAIDEN NAME
Barbara Broadwater | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT Address
Memorial Hospital, Cumberland, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
420.1 DUE TO Chr Myocarditis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Semility
DUE TO (c) Semility | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 8 days P.O. - 21 July 56 Intestinal Obst. Hydrops Gall Bladder | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 19 July 1956 , to 29 July 1956 , that I last saw the deceased alive on 29 July 1956 , and that death occurred at 6.10pm , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Fuller B. Whitworth M.D. | | | | ADDRESS (Street, city or town, state) 123 Bedford St | | | |
| DATE SIGNED 30 July 56 | | | | | | | |
| PHYSICIAN'S NAME (Type) FULLER B. WHITWORTH | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
August 1, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY
Philos Cemetery | | 22d. LOCATION (City, town, or county) (State)
Westernport, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Boal's Funeral Home, Westernport, Maryland. | | | | 24a. REC'D BY REGISTRAR
July 31, 1956 | | 24b. REGISTRAR'S SIGNATURE
W. R. Frank, M.D. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

AUG 1 1956

BUREAU V. 3

RECEIVED

| | | | |
|--|--|--|--|
| <p>1. Name of deceased: John Doe</p> | | <p>2. Sex: Male</p> | |
| <p>3. Date of birth: Jan 15, 1900</p> | | <p>4. Place of birth: St. Louis, Mo.</p> | |
| <p>5. Date of death: Aug 1, 1956</p> | | <p>6. Place of death: St. Louis, Mo.</p> | |
| <p>7. Cause of death: Heart Disease</p> | | <p>8. Manner of death: Natural</p> | |
| <p>9. Signature of physician: John Doe</p> | | <p>10. Signature of registrar: John Doe</p> | |
| <p>11. Signature of informant: John Doe</p> | | <p>12. Signature of witness: John Doe</p> | |

6741

CERTIFICATE OF DEATH

06728

Reg. Dist. No.

4

| | | | | | |
|--|----------------------------------|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | c. LENGTH OF STAY IN 1b
11/8/52 | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Allegany County Infirmary | | | e. STREET ADDRESS
523 Louisiana Avenue | | |
| 3. NAME OF DECEASED (Type or print)
First John Middle G. Last Douglas | | | 4. DATE OF DEATH
Month July Day 23 Year 1956 | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6/29/1867 | | 9. AGE (In years last birthday)
89 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired - Coal Mining | | | 10b. KIND OF BUSINESS OR INDUSTRY
Lonaconing, Maryland | | 11. BIRTHPLACE (State or foreign country)
U. S. A. |
| 13. FATHER'S NAME
John Douglas | | | 14. MOTHER'S MAIDEN NAME
Mary Ghrame | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | | 16. SOCIAL SECURITY NO.
Allegany County Infirmary Records | | |
| 17. INFORMANT
Allegany County Infirmary Records | | | Address P.O. Box 599 | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Hypertosis
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis
(c) Severe Arteriosclerosis | | | | | INTERVAL BETWEEN ONSET AND DEATH
24 hrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Prostatitis | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from 11/8/52 , 19____, to 7/23/56 , 19____, that I last saw the deceased alive on 7/23/56 , 19____, and that death occurred at 11:25 PM , from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE
James E. McLean | | | ADDRESS (Street, city or town, state) 49 Greene St., Cumberland, Md. DATE SIGNED 7/24/56 | | |
| PHYSICIAN'S NAME (Type)
Dr. James E. McLean | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
7/26/56 | | 22c. NAME OF CEMETERY OR CREMATORY
Oak Hill Cemetery | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
George Eichhorn | | ADDRESS
Lonaconing, Md. | | 24a. REC'D BY REGISTRAR
July 26, 1956 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Walter R. Hantz, M.D. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Allegany

Greenland

11/8/52

Allegany County, Maryland

John

White

Male

Retired - Coal Mining

John Douglas

Maryland

Greenland

253 Louisiana Avenue

Douglas

July

6/29/1867

Longwood, Maryland

Mary Christine

Allegany County, Maryland Records
P.O. Box 299

11/8/52

11/8/52

Dr. James E. Nolan

JUL 27 1956

BUREAU A. B.

RECEIVED

1

INSTRUCTIONS

TO A FUNDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06729

6795

CERTIFICATE OF-DEATH

Reg. Dist. No. 8

| | | | | | | | |
|---|----------------------------------|--|--|---|--------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)
TOWN <u>Lonaconing</u> | | LENGTH OF STAY
(in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN <u>Lonaconing</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
<u>High Street</u> | | | | STREET ADDRESS
(If rural give location)
<u>High Street</u> | | | |
| 3. NAME OF DECEASED
(Type or Print) <u>Anna Duckworth</u> | | | | 4. DATE OF DEATH
(Month) (Day) (Year)
<u>July 25 1956</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
<u>Widowed</u> | 8. DATE OF BIRTH
<u>June 27, 1875</u> | 9. AGE last birthday
<u>81</u> yrs. | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>House Work</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Frostburg, MD.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Thomas Murphy</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Harriet Larue</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.)
<u>NOB</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT & ADDRESS
<u>Calvin Duckworth, (SON)</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION
<u>Lonaconing, MD.</u> | | | |
| 420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u> | | | | INTERVAL BETWEEN ONSET, AND DEATH
<u>1 hour</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>July 25, 1956</u> , to <u>July 25, 1956</u> , that I last saw the deceased alive on <u>July 25, 1956</u> , and that death occurred at <u>7:30</u> A.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
<u>Fred R. Miles Jr.</u> | | M.D.
<u>Lonaconing Md</u> | | ADDRESS (Street, city, town, state)
<u>July 25 1956</u> | | DATE SIGNED | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | DATE THEREOF
<u>July 27, 1956</u> | | NAME OF CEMETERY OR CREMATORY
<u>Oak Hill Cemetery Lonaconing, Md.</u> | | LOCATION (City, town, or county) (State) | |
| 24. REC'D BY REGISTRAR
DATE <u>7/28/56</u> | | REGISTRAR'S SIGNATURE
<u>Jeanette M. Boal</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>George Eichhorn</u> | | ADDRESS
<u>Lonaconing, Md.</u> | |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|------------------------|--|----------------------|--|-------------------------------|--|-----------------------------|--|--------------------|--|------------------------|--|
| Name of Deceased | | Age | | Sex | | Race | | Date of Birth | | Date of Death | |
| Place of Birth | | Usual Residence | | Cause of Death | | Manner of Death | | Occupation | | Signature of Physician | |
| Signature of Registrar | | Signature of Coroner | | Signature of Medical Examiner | | Signature of Health Officer | | Signature of Clerk | | Signature of Treasurer | |

BUREAU V. S.

AUG 3 1956

RECEIVED

6742

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>48. Browning St</u> | | | | d. STREET ADDRESS
<u>48. Browning St</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Joanna</u> Middle <u>Joanna</u> Last <u>Dunlap</u> | | | | 4. DATE OF DEATH
Month <u>July</u> Day <u>22</u> Year <u>1956</u> | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Oct 16 1866</u> | |
| 9. AGE (In years last birthday) yrs. <u>89</u> | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS.
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>House Wife</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Cumberland Md</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | | | | | |
| 13. FATHER'S NAME
<u>Cheston Johnson</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Louise Jackson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
<u>Thomas Ricker, Cumberland, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>422.1</u>
DUE TO <u> </u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Chronic Myocarditis</u>
DUE TO <u> </u>
(c) <u>Arteriosclerosis</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>6 wks.</u>
<u>3 yrs.</u>
<u>5 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | |
| 20f. (City or town)
<u> </u> | | | | 20g. (County)
<u> </u> | | 20h. (State)
<u> </u> | |
| 21. I certify that I attended the deceased from <u>Jan 1951</u> , to <u>July 22, 1956</u> , that I last saw the deceased alive on <u>July 21, 1956</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Clayton Durrett</u> | | | | ADDRESS (Street, city or town, state) <u>236 W. Longwood, Pa.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>W. R. Frantz</u> | | | | DATE SIGNED <u>7/23/56</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>July 25 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Hyndman Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Hyndman Pa</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. R. Frantz</u> | | | | ADDRESS <u>Cumberland, Md.</u> | | 24a. REC'D BY REGISTRAR <u>W. R. Frantz, M.D.</u> | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE <u> </u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06791

Reg. Dist. No.

| | | | | | |
|--|--|--|---|-----------------------------|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>Md</u> b. COUNTY <u>Allegany</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | c. LENGTH OF STAY IN lb
<u>4 hrs</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Memorial Hospital</u> | | | d. STREET ADDRESS
<u>826 Mt. Royal Ave.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First <u>Robert</u> Middle <u>Little</u> Last <u>Ebert</u> | | | 4. DATE OF DEATH
Month <u>July</u> Day <u>22</u> Year <u>19 56</u> | | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Jan 20-1950</u> | | 9. AGE (In years last birthday)
<u>6</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Child</u> | 11. BIRTHPLACE (State or foreign country)
<u>Cumberland, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 13. FATHER'S NAME
<u>Robert Little Ebert Sr.</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Elta May Schultz</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>none</u> | 17. INFORMANT
<u>Memorial Hospital records</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Shock, head injuries with a depressed skull fracture-</u>
<u>902.0</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>fracture, intracranial hemorrhage, cerebral</u>
DUE TO
(c) <u>injury extensive. Fell from an apple tree.</u>
5 hrs. | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Port II of item 18.)
<u>Climbed apple tree, fell about 12 ft. striking on head.</u> | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <u>12:15</u> on <u>7-22</u> 19 <u>56</u>
a. m. <u>7</u> p. m. <u>22</u> | 20d. INJURY OCCURRED
White <input type="checkbox"/> Not white <input checked="" type="checkbox"/>
of work <input type="checkbox"/> of work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Back yard, Home</u> | 20f. (City or town)
<u>Cumberland</u> | (County)
<u>Allegany</u> | (State)
<u>Md.</u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE
<u>H. V. Deming M.D.</u> | | | DATE SIGNED
<u>July 23-1956</u> | | |
| EXAMINER'S NAME (Type)
<u>H. V. Deming M.D.</u> | | | DEPUTY MEDICAL EXAMINER
<u>July 23-1956</u> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>July 24, 1956</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Hillcrest Burial Park</u> | 22d. LOCATION (City, town, or county) (State)
<u>Cumberland, Maryland</u> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>John J. Hafer, Cumberland, Maryland.</u> | | 23a. REC'D BY REGISTRAR
<u>July 24, 1956</u> | 23b. REGISTRAR'S SIGNATURE
<u>W. R. Frantz, M.D.</u> | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 3

JUL 25 1956

RECEIVED

CERTIFICATE OF DEATH

6744

Reg. Dist. No. 4

| | | | | | | | |
|---|----------------------------------|---|--|--|--------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN <u>Cumberland</u> | | LENGTH OF STAY (In this place)
<u>5 wks</u> | | CITY (If outside corporate limits, write RURAL and give nearest town)
OR TOWN <u>Cumberland</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
<u>127 South Mechanic Street</u> | | | | STREET ADDRESS (If rural give location)
<u>127 South Mechanic Street</u> | | | |
| 3. NAME OF DECEASED (Type or Print)
(First) <u>SILAS</u> (Middle) <u>ELBIN</u> (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year)
<u>July 10 19 56</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
<u>Widowed</u> | 8. DATE OF BIRTH
<u>Apr. 20, 1870</u> | 9. AGE last birthday
<u>86</u> yrs. | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Janitor & Odd</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Elbinsville, Penn.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>George Elbin Jobs</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Naomi Lashley</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>216-22-5283</u> | | 17. INFORMANT & ADDRESS
<u>127 So. Mechanic St. Ada Hamburg, Cumberland, Maryland</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 155X IMMEDIATE CAUSE (A) <u>Carcinoma Liver with metastases</u> | | | | | | <u>Unknown</u> | |
| ANTECEDENT CAUSE(S) (B) <u>Arteriosclerosis</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>June 19, 56</u> , to <u>July 10, 56</u> , that I last saw the deceased alive on <u>July 8, 56</u> , and that death occurred at <u>3:00 AM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
<u>John J. Hafer</u> | | ADDRESS (Street, city, town, state)
<u>M.D. 133 Virginia Ave, Cumberland, Md</u> | | DATE SIGNED
<u>JULY 10 1956</u> | | | |
| 23. MANNER, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | DATE THEREOF
<u>July 12, '56</u> | | NAME OF CEMETERY OR CREMATORY
<u>Pleasant Grove Cem.</u> | | LOCATION (City, town, or county) (State)
<u>Allegany County, Md.</u> | |
| 24. REC'D BY REGISTRAR
<u>July 12, 1956</u> | | REGISTRAR'S SIGNATURE
<u>Walter R. Frantz, M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>John J. Hafer</u> | | ADDRESS
<u>Cumberland, Md.</u> | |

INSTRUCTIONS

1. TO A FUNERAL PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

When Corporate Limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06733

CERTIFICATE OF DEATH

6745

Reg. Dist. No. 4

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY
Allegany | STATE
Maryland | COUNTY
Allegany | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
Cumberland | LENGTH OF STAY (in this place)
1/18/56 | CITY (If outside corporate limits, write RURAL and give nearest town)
Cumberland | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
Allegany County Infirmary | STREET ADDRESS (If rural give location)
23 New Hampshire Avenue | | |

| | | | | | |
|-------------------------------------|--------------------------|------------------------|------------------------|--------------------|------------------------|
| 3. NAME OF DECEASED (Type or Print) | | | 4. DATE OF DEATH | | |
| (First)
(Evans) Sarah B. | (Middle)
Evans | (Last)
Evans | (Month)
July | (Day)
29 | (Year)
19 56 |

| | | | | | | |
|-------------------------|----------------------------------|--|-------------------------------------|--------------------------------------|--------------------------------|--------------------------------|
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
Widow | 8. DATE OF BIRTH
3/8/1875 | 9. AGE at birthday
81 yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
|-------------------------|----------------------------------|--|-------------------------------------|--------------------------------------|--------------------------------|--------------------------------|

| | | | |
|---|--|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | 11. BIRTHPLACE (State or foreign country)
Frostburg, Maryland | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. |
|---|--|---|---|

| | |
|---|--|
| 13. FATHER'S NAME
Charles Brode | 14. MOTHER'S MAIDEN NAME
Catherine Gerlock |
|---|--|

| | | |
|--|--|---|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.)
No | 16. SOCIAL SECURITY NO.
None | 17. INFORMANT & ADDRESS
P. O. Box 599 Allegany County Infirmary Records |
|--|--|---|

| | | | | | |
|---|--|---------------------------------|--|----------------------------------|--|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (A)
4221 | | Chronic Myocarditis | | ? | |
| ANTECEDENT CAUSE(S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | General Arteriosclerosis | | ? | |
| | | Cerebral Hemorrhage | | ? | |
| | | Chronic Nephritis | | ? | |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | |

| | | |
|--|--|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from **7/18/**, 19**56**, to **7/29/**, 19**56**, that I last saw the deceased alive on **1/29/**, 19**56**, and that death occurred at **M.** from the causes and on the date stated above.

| | | |
|---|---|-------------------------------|
| SIGNATURE
Dr. James E. McLean | ADDRESS (Street, city, town, state)
M.D. 49 Greene St., Cumberland, Md. | DATE SIGNED
7/30/56 |
|---|---|-------------------------------|

| | | | |
|---|--------------------------------|--|---|
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | DATE THEREOF
7/31/56 | NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | LOCATION (City, town, or county) (State)
Cumberland, Maryland |
|---|--------------------------------|--|---|

| | | | |
|--|---|--|--|
| 24. REC'D BY REGISTRAR
July 31, 1956 | REGISTRAR'S SIGNATURE
Walter R. Frantz M.D. | 25. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer | ADDRESS
Cumberland, Maryland |
|--|---|--|--|

INSTRUCTIONS

TO APPENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

118728

Allegany County Infirmary
 Cumberland
 Allegany
 23 New Hampshire Avenue
 Cumberland

(Evans) Sarah E. Evans
 July 23, 1956

3/8/1956

Frostburg, Maryland

Charles Brode

Operating Service

Allegany County Infirmary Records
 P. O. Box 99

BUREAU V. S.

AUG 1 1956

RECEIVED

NOTIFICATION

TO THE CLERK OF THE DISTRICT COURT OF THE DISTRICT OF COLUMBIA
 FROM THE CLERK OF THE DISTRICT COURT OF THE DISTRICT OF COLUMBIA
 TO THE CLERK OF THE DISTRICT COURT OF THE DISTRICT OF COLUMBIA
 FROM THE CLERK OF THE DISTRICT COURT OF THE DISTRICT OF COLUMBIA

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6796

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06734

Reg. Dist. No.

| | | | |
|---|-----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission)
a. STATE <u>W.Va.</u> b. COUNTY <u>Hampshire</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Old Town</u> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route # 51</u> | | d. STREET ADDRESS <u>Augusta</u> <u>85X-3</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Asa</u> Middle <u>Eskridge</u> Last <u>Everett</u> | | 4. DATE OF DEATH
Month <u>July</u> Day <u>6</u> Year <u>19 56</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 27-1888</u> |
| 9. AGE (In years last birthday) <u>67</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS.
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired, machinest helper-B&O.R.Ry.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Shanks, W.Va.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Jacob E. Everett</u> | | 14. MOTHER'S MAIDEN NAME <u>Amanda C. Swisher</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>721-16-9550</u> | |
| 17. INFORMANT <u>Mrs. Parsy Davis, Old Town, Md.</u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage due to a fractured skull, comminuted fracture of left femur & humerous also nose.</u>
DUE TO (b) <u> </u>
DUE TO (c) <u> </u>
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Walking, route 51, hit & run, near Old Town, Md.</u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year <u>12-25-7-6</u> 19 <u>56</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rt. 51</u> | | 20f. (City or town) <u>near Old Town Allegany</u> (County) <u> </u> (State) <u>Md.</u> | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>H. V. Deming M.D.</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <u>July 6-1956</u> | | DATE SIGNED <u> </u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>7-8-1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u> | 22d. LOCATION (City, town, or county) (State) <u>Points, W. Va.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u> | | ADDRESS <u> </u> | |
| 23a. REC'D BY REGISTRAR <u>July 8, 1956</u> | | 23b. REGISTRAR'S SIGNATURE <u>Mrs. Taylor</u> | |

16 JUL 1956

RECEIVED

6785

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|---------------------------------------|--|---------------------------|---|---------------------------|
| 1. PLACE OF DEATH
o. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Frostburg</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Frostburg, Route 2</u> 11X-2 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Miners Hospital</u> | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>NORMAN</u> Middle <u>GARLITZ</u> Last <u>GARLITZ</u> | | | | 4. DATE OF DEATH
Month <u>July</u> Day <u>18</u> Year <u>19 56</u> | | | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>11-10-1883</u> | 9. AGE (In years last birthday)
<u>72</u> yrs. | IF UNDER 1 YEAR
Months | IF UNDER 24 HRS.
Days | IF UNDER 24 HRS.
Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>farming</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>own farm</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | |
| 10c. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>George Garlitz</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Nancy Durst</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
<u>189-22-6902</u> | | 17. INFORMANT
<u>Mrs. Norman Garlitz, Rt. 2, Frostburg, Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchial pneumonia</u>
491X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) _____
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 wks</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
White <input type="checkbox"/> Not white <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <u>July 9, 1956</u> , to <u>July 18, 1956</u> , that I last saw the deceased alive on <u>July 18, 1956</u> , and that death occurred at <u>4:20 P</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Hilda Jane Walters</u> | | | | ADDRESS (Street, city or town, state) <u>48 Broadway, Frostburg, Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Hilda Jane Walters, M. D.</u> | | | | DATE SIGNED <u>7-19-56</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>7-21-1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Blocher Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Garrett County, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>J. R. Durst, Frostburg, Md.</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>7-20-56</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Mr B O Price</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

DR. SIMONS

6746

CERTIFICATE OF DEATH

Reg. Dist. No.

4

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
o. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LA VALE | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL | | d. STREET ADDRESS
BOX 128 | |
| 3. NAME OF DECEASED (Type or print)
First CLARENCE Middle E Last GEHR | | 4. DATE OF DEATH
Month JULY Day 19 Year 1956 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
AUG. 2, 1889 |
| 9. AGE (In years last birthday)
66 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Ret. Frt. Agent | | 10b. KIND OF BUSINESS OR INDUSTRY
W.M. Railroad | |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND, Indian Springs | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JOHN GEHR | | 14. MOTHER'S MAIDEN NAME
MARY COOK | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> yes (If yes, give war or dates of service) W.W.I | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
MEMORIAL HOSPITAL-WARWICK & MEMORIAL AVES. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 7/1/56 , 19 56 , to 7/1/56 , 19 56 , that I last saw the deceased alive on 7/1/56 , 19 56 , and that death occurred at 11:35 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Cumberland Md 128 Union St. DATE SIGNED 7/2/56 | | | |
| ACTUAL SIGNATURE George M. Simons M.D. | | PHYSICIAN'S NAME (Type) DR. GEORGE M. SIMONS | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7/22/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Rest Haven Cemetery | | 22d. LOCATION (City, town, or county) (State)
Hagerstown, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Maryland | | 24a. REC'D BY REGISTRAR
July 22, 1956 | |
| 24b. REGISTRAR'S SIGNATURE
R. Frank M.D. | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06737

Reg. Dist. No. 4

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY 6747 Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Md. b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
02 Cumberland | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
02 Cumberland | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Back yard at home. 108 N. Smallwood St. | | d. STREET ADDRESS
108 N. Smallwood St. | |
| 3. NAME OF DECEASED
(Type or print)
First Frederick Middle J. Grabenstein Last | | 4. DATE OF DEATH
Month July Day 7 Year 19 56 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug. 1-1870 |
| 9. AGE (In years last birthday)
85 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired-Merchant | | 10b. KIND OF BUSINESS OR INDUSTRY
Meat Market | |
| 11. BIRTHPLACE (State or foreign country)
Mineral Co. W. Va. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Justus Grabenstein | | 14. MOTHER'S MAIDEN NAME
Margaret Mundy | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
Mrs. R. Everstein, Cumberland, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 Coronary sclerosis
DUE TO (b) Chronic myocarditis with ascites
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH
? several years. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE
H. V. Deming M.D. | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 7-1956 | |
| EXAMINER'S NAME (Type) H. V. Deming M.D. | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
7-10-1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY
S.S. Peter & Paul Cem. | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles L. George | | ADDRESS
Cumberland, Md. | |
| 24a. REC'D BY REGISTRAR
July 9/1956 | | 24b. REGISTRAR'S SIGNATURE
W. L. Frank, M.D. | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a separate certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND - BALTIMORE 18

| | | | | | | | | | | | |
|-------------------------------|--|----------------------|--|--------------------|--|--------------------|--|------------------------|--|--------------------|--|
| Name of Deceased | | Sex | | Age | | Race | | Date of Death | | Place of Death | |
| Occupation | | Cause of Death | | Manner of Death | | Medical History | | Postmortem Examination | | Remarks | |
| Signature of Medical Examiner | | Signature of Coroner | | Signature of Juror | | Signature of Juror | | Signature of Juror | | Signature of Juror | |

RECEIVED
JUL 10 1956
BUREAU V. B.

6748

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|-------------------------------|--|---------------------------------------|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | | | c. LENGTH OF STAY IN 1b 51 years | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | | | d. STREET ADDRESS 38 Grand Ave. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 38 Grand Ave. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Richard Middle Henry Last Guthridge | | | | 4. DATE OF DEATH Month July Day 16 Year 1956 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 25, 1882 | 9. AGE (In years last birthday) 73 yrs. | IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min. 73 | IF UNDER 24 HRS. Months 73 Days 73 Hours 73 Min. 73 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Brakeman | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | | 11. BIRTHPLACE (State or foreign country) Brownsville, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 705-09-3740 | | 17. INFORMANT Address Mrs. Richard H. Guthridge, Cumberland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis
DUE TO Art Sch/ Corp
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 3 yrs
(b) Art Sch/ Corp
DUE TO Art Sch/ Corp
(c) Art Sch/ Corp | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4/15/52 , 19 52 , to 7/16/56 , 19 56 , that I last saw the deceased alive on 7/14/56 , 19 56 , and that death occurred at 3 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Richard J. Williams | | | | ADDRESS (Street, city or town, state) M.D. 122 S. Centre Street | | DATE SIGNED 7/17/56 | |
| PHYSICIAN'S NAME (Type) Richard J. Williams, M.D. Cumberland, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF July 19, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY Hillcrest | | 22d. LOCATION (City, town, or county) (State) Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md. | | | | 24a. REC'D BY REGISTRAR July 18, 1956 | | 24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D. | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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JUN 9 1956
BUREAU V. 51

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BUREAU V. S.

6797
CERTIFICATE OF DEATH

Reg. Dist. No. 9

| | | | | | | | |
|--|----------------------------------|---|--|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Midlothian | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Midlothian | | | |
| c. LENGTH OF STAY IN 1b
Lifetime | | | | d. STREET ADDRESS
Midlothian | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Anthony Middle Harvey Last Harvey | | | | 4. DATE OF DEATH
Month July Day 25 Year 19 56 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 9, 1879 | 9. AGE (In years last birthday)
77 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Judge | | | | 10b. KIND OF BUSINESS OR INDUSTRY
People's Court | | 11. BIRTHPLACE (State or foreign country)
Midlothian | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Robert Harvey | | | | 14. MOTHER'S MAIDEN NAME
Mary Gibson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Mrs. Elmer Jones Frostburg, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arterio Sclerosis
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Insufficiency
DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH
Several years
4 yrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1954 19____, to July 25 , 19 56 , that I last saw the deceased alive on June 23 , 19 56 , and that death occurred at 7:30 AM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Frostburg Md. DATE SIGNED July 25 1956 | | | | | | | |
| ACTUAL SIGNATURE WOMC Lane MD | | | | PHYSICIAN'S NAME (Type) WOMC Lane MD | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
7-28-56 | | 22c. NAME OF CEMETERY OR CREMATORY
Frostburg Memorial Park Frostburg Md. | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
B.H. Montisant | | | | ADDRESS
HAFFER FUNERAL HOME E. MAIN, FROSTBURG, MD. | | 24a. REC'D BY REGISTRAR
DATE 7-30-56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Duo Nancy H. Re | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | |
|---|------------------------|--|--------------------------------|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE WEST VIRGINIA b. COUNTY HARDY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MOOREFIELD | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First MIDDLE Last ETHEL J. HEDRICK | | 4. DATE OF DEATH Month JULY Day 25 Year 1956 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH FEB. 20, 1899 |
| 9. AGE (In years last birthday) 57 | | IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Laborer in Poultry Dressing Plant | | 10b. KIND OF BUSINESS OR INDUSTRY Hardy County, W. Va. | |
| 11. BIRTHPLACE (State or foreign country) USA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME CLARK HEAVNER | | 14. MOTHER'S MAIDEN NAME Martha L. Heavner | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 235-30-0123 | |
| 17. INFORMANT Mrs. Nellie Ebert, Moorefield, West Virginia. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 331X Cerebral Hemorrhage
DUE TO (b) Hypertensive Vascular Disease
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH 5 July 1956 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5 July, 1956, to 25 July, 1956, that I last saw the deceased alive on 25 July, 1956, and that death occurred at 6:50 A.M. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) DATE SIGNED 25 July 56 | |
| ACTUAL SIGNATURE W. A. Van Ormer | | M.D. C. W. Belmont, Jr. | |
| PHYSICIAN'S NAME (Type) W. A. VAN ORMER | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7-27-56 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mount Cemetery | | 22d. LOCATION (City, town, or county) (State) Moorefield, West Virginia. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Thos. H. Hume | | ADDRESS Moorefield | |
| 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE W. D. Frank, M.D. | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 27 1956

6750

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY Allegheny | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RAWLINGS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL | | d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First IVY Middle S Last HIGGS. | | 4. DATE OF DEATH Month JULY Day 17 Year 19 56 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 9, 1887 |
| 9. AGE (In years last birthday) 68 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10b. KIND OF BUSINESS OR INDUSTRY Own home | |
| 11. BIRTHPLACE (State or foreign country) ENGLAND | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME THOMAS MEDLIN | | 14. MOTHER'S MAIDEN NAME LENA LAWRENCE | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Address Mrs. Franklin Sherwood, Rawlings, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH Sudden |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes Mellitus | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
of work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 6-18-1956 , to 7-17-1956 , that I last saw the deceased alive on 7-17-1956 , and that death occurred at 8:35 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE W. F. Williams M.D. | | ADDRESS (Street, city or town, state) Cumberland Md. DATE SIGNED 7-18-56 | |
| PHYSICIAN'S NAME (Type) DR. W.F. WILLIAMS | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF July, 20, 1956 | 22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | 22d. LOCATION (City, town, or county) (State) Forest Park, Ill. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, ADDRESS Cumberland, Md. | | 24a. REC'D BY REGISTRAR July 20, 1956 | 24b. REGISTRAR'S SIGNATURE Walter R. Frank, M.D. |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6751

CERTIFICATE OF DEATH

06742

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland, | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland, | |
| c. LENGTH OF STAY IN 1b
Lifetime | | d. STREET ADDRESS
718 Yale St., | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
718 Yale St., | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First ROY Middle OLIVER Last HINKLE | | 4. DATE OF DEATH
Month July Day 2, Year 19 56 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 26, 1895 |
| 9. AGE (In years last birthday)
61 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY
Construction | |
| 11. BIRTHPLACE (State or foreign country)
Cumberland, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
James O. S. Hinkle | | 14. MOTHER'S MAIDEN NAME
Susan Wilson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No, | | 16. SOCIAL SECURITY NO.
217-10-7219 | |
| 17. INFORMANT
Mrs. Mamie Hinkle | | Address
718 Yale St., Cumb. Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | INTERVAL BETWEEN ONSET AND DEATH
5 minutes
Not done | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6/15/56 19____, to 7/2/56 19____, that I last saw the deceased alive on 6/15/56 19____, and that death occurred at 12:05 P.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 122 So. Centre St., DATE SIGNED _____
ACTUAL SIGNATURE _____
PHYSICIAN'S NAME (Type) Richard J. Williams M. D. Cumberland, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
7/4/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Greenmount Cemetery | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
H. Wayne George | | ADDRESS
Cumberland, Maryland | |
| 24a. REC'D BY REGISTRAR
DATE 7/3, 1956 | | 24b. REGISTRAR'S SIGNATURE
W. R. Lamb, M.D. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME: [illegible] SEX: [illegible] AGE: [illegible] DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible] OCCUPATION: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF DEATH: [illegible] TIME OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

REGISTRAR: [illegible]

DATE OF REGISTRATION: [illegible]

FILE NO.: [illegible]

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 JUL 5 1956
 BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06743

Reg. Dist. No.

9

6787

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frostburg
c. LENGTH OF STAY IN 1b
Rural) Rt. #3 Myersdale
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
D.O.A. Miners Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
a. STATE Pa. b. COUNTY Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural) Rt. #3 Myersdale
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Wayne Middle Joseph Last Hostetler | | 4. DATE OF DEATH
Month July Day 29 Year 19 56 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH
Feb. 20-1953 | 9. AGE (In years last birthday) 3 yrs.
10. IF UNDER 1 YEAR
Months 3 Days 0 Hours 0 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
none | | 10b. KIND OF BUSINESS OR INDUSTRY
none | |
| 11. BIRTHPLACE (State or foreign country)
Myersdale, Pa. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
C. Carl Hostetler | | 14. MOTHER'S MAIDEN NAME
Verna Catherine Clark | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
(father) C. Carl Hostetler, Myersdale, Pa. | | Address R.F.D. #3 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia due to
DUE TO Strangulation (accidental)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
936.0
DUE TO sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
about 88
cord, which hung on a nail.
Unknown manner, found with head through loop of baling | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.
3.15 p.m. 7-29 1956 | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury and how it occurred)
In shed, at home Myersdale, Somerset Pa. | |
| 20c. TIME OF INJURY Month, Day, Year
3.15 p.m. 7-29 1956 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home; farm, factory, street, office bldg., etc.)
Rural, Rt. #3 (County) Somerset Pa. | | 20f. CITY OR TOWN (State)
Myersdale, Pa. | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from:
Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
H. V. Deming M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 29-1956 | |
| EXAMINER'S NAME (Type)
H. V. Deming M.D. | | DATE SIGNED
July 29-1956 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
8-1-56 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Finzel Cemetery | | 22d. LOCATION (City, town, or county) (State)
Finzel Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Buried H. Montsant | | 24a. REC'D BY REGISTRAR
DATE 8-1-56 | |
| 24b. REGISTRAR'S SIGNATURE
Miss Nancy N. Rose | | 24c. ADDRESS
23 E. Main, Frostburg | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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BUREAU V. 3

Aug 5 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 4

6752

| | | | | | | | |
|--|-------------------------------|--|---|---|---|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | STATE <u>Maryland</u> COUNTY <u>Allegany</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cresaptown,</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cresaptown,</u> | |
| CITY OR TOWN <u>Cumberland,</u> | | LENGTH OF STAY (in this place) | | STREET ADDRESS (If rural give location) | | STREET ADDRESS | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hosp.</u> | | | | <u>Cresap Park</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>DELLA FLORENCE KILE</u> | | | | <u>July 23, 19 56</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>January 8, 1869</u> | 9. AGE last birthday <u>87</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | 11. BIRTHPLACE (State or foreign country) <u>Pendleton Co., W. Va.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> | | |
| 13. FATHER'S NAME <u>Morgan D. Lambert</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Martha Ann Simmons</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS <u>Mr. Jesse H. Simmons Kidgeley, W. Va.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 331X IMMEDIATE CAUSE (A) <u>Cerebral vascular accident</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral sclerosis</u> | | | | | | <u>5 years</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>6-30</u> , 19 <u>56</u> , to <u>7-23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7-23</u> , 19 <u>56</u> , and that death occurred at <u>7:30 A.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Lessa G. Bacon</u> | | | | ADDRESS (Street, city, town, state) <u>M.D. 62 Greene St., Cumberland, Md.</u> | | DATE SIGNED <u>7/23/56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>7/25/56</u> | | NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Franklin, W. Va.</u> | |
| 24. REC'D BY REGISTRAR <u>July 23, 1956</u> | | REGISTRAR'S SIGNATURE <u>Winters R. Frank, M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u> ADDRESS <u>Cumberland, Maryland</u> | | | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

CERTIFICATE OF DEATH

| | | | |
|--------------------------------|--|--------------------------------|--|
| Name of Deceased
_____ | | Date of Death
_____ | |
| Sex
_____ | | Age
_____ | |
| Race
_____ | | Birth Date
_____ | |
| Place of Birth
_____ | | Usual Residence
_____ | |
| Cause of Death
_____ | | Manner of Death
_____ | |
| Physician's Signature
_____ | | Registrar's Signature
_____ | |
| Date of Declaration
_____ | | Place of Declaration
_____ | |

BUREAU V. 3

JUL 24 1956

RECEIVED

INSTRUCTIONS

This certificate is to be filled out by the physician or other person authorized by the State Department of Health. It should be filled out as soon as possible after death, and before the body is buried or cremated. It should be filled out in the presence of the coroner or other official authorized by the State Department of Health. It should be filled out in the presence of the coroner or other official authorized by the State Department of Health. It should be filled out in the presence of the coroner or other official authorized by the State Department of Health.

1

M

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06745

CERTIFICATE OF DEATH

6753

Reg. Dist. No. 4

| | | | | | | | |
|---|------------------|--|------------------|--|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | STATE <u>Maryland</u> COUNTY <u>Allegany</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) | | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | TOWN <u>Mt. Savage</u> | | TOWN <u>Mt. Savage</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural give location) | | STREET ADDRESS | | STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or Print) | | (First) (Middle) (Last) | | 4. DATE OF DEATH (Month) (Day) (Year) | | 4. DATE OF DEATH (Month) (Day) (Year) | |
| Joseph Phillip Kirby | | Joseph Phillip Kirby | | 7-25-1956 | | 19 | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | IF UNDER 24 HRS. | IF UNDER 24 HRS. |
| M | W | W | 12-31-1872 | 83 yrs. | Months | Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| retired laborer | | brick yard | | Maryland | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Phillip Kirby | | | | Sarah Metz | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| (If Yes, give war or dates of service) | | 213-10-9122 | | Roy Kirby, Mt. Savage, Md. | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 592X IMMEDIATE CAUSE (A) | | | | Chronic Myocardial Deterioration | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | Coronary Arteriosclerosis | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO | | | | Chronic Nephritis. | | | |
| (C) | | | | Senile psychosis. | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from July 2, 1956, to July 25, 1956, that I last saw the deceased alive on July 24, 1956, and that death occurred at M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | ADDRESS (Street, city, town, state) | | DATE SIGNED | | DATE SIGNED | |
| James B. Cheave, M.D. | | 49 Greiner St. | | 7-25-56 | | 7-25-56 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Burial | | 7-27-56 | | Methodist Cemetery | | Mt. Savage, Md. | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| DATE 7/27/56 | | W. P. Drantz, M.D. | | J. R. Durst, Frostburg, Md. | | J. R. Durst, Frostburg, Md. | |

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. DATE OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF FUNERAL HOME

15. SIGNATURE OF BURIAL SOCIETY

16. SIGNATURE OF CEMETERY

17. SIGNATURE OF INTERVIEWER

18. SIGNATURE OF CLERK

19. SIGNATURE OF ASSISTANT CLERK

20. SIGNATURE OF RECEPTIONIST

21. SIGNATURE OF TELEPHONE OPERATOR

22. SIGNATURE OF MAIL ROOM

23. SIGNATURE OF RECORDS SECTION

24. SIGNATURE OF STATISTICS SECTION

25. SIGNATURE OF LABORATORY

26. SIGNATURE OF RADIOLOGY

27. SIGNATURE OF PATHOLOGY

28. SIGNATURE OF BACTERIOLOGY

29. SIGNATURE OF VIROLOGY

30. SIGNATURE OF IMMUNOLOGY

31. SIGNATURE OF EPIDEMIOLOGY

32. SIGNATURE OF PUBLIC HEALTH

33. SIGNATURE OF COMMUNITY HEALTH

34. SIGNATURE OF SCHOOL HEALTH

35. SIGNATURE OF OCCUPATIONAL HEALTH

36. SIGNATURE OF ENVIRONMENTAL HEALTH

37. SIGNATURE OF NUTRITION

38. SIGNATURE OF PHYSICAL EDUCATION

39. SIGNATURE OF RECREATION

40. SIGNATURE OF ARTS AND CRAFTS

41. SIGNATURE OF MUSIC

42. SIGNATURE OF THEATRE

43. SIGNATURE OF FILM

44. SIGNATURE OF TELEVISION

45. SIGNATURE OF RADIO

46. SIGNATURE OF PRESS

47. SIGNATURE OF LITERATURE

48. SIGNATURE OF ARTS

49. SIGNATURE OF CRAFTS

50. SIGNATURE OF DESIGN

51. SIGNATURE OF ARCHITECTURE

52. SIGNATURE OF ENGINEERING

53. SIGNATURE OF AGRICULTURE

54. SIGNATURE OF FISHERY

55. SIGNATURE OF MINING

56. SIGNATURE OF MANUFACTURING

57. SIGNATURE OF TRANSPORTATION

58. SIGNATURE OF COMMUNICATIONS

59. SIGNATURE OF PUBLIC UTILITIES

60. SIGNATURE OF FIRE PROTECTION

61. SIGNATURE OF POLICE

62. SIGNATURE OF FIRE DEPARTMENT

63. SIGNATURE OF PLANNING

64. SIGNATURE OF ZONING

65. SIGNATURE OF LAND USE

66. SIGNATURE OF HOUSING

67. SIGNATURE OF COMMUNITY DEVELOPMENT

68. SIGNATURE OF ECONOMIC DEVELOPMENT

69. SIGNATURE OF LABOR RELATIONS

70. SIGNATURE OF TRADE UNIONS

71. SIGNATURE OF EMPLOYERS

72. SIGNATURE OF GOVERNMENT

73. SIGNATURE OF NON-PROFIT

74. SIGNATURE OF BUSINESS

75. SIGNATURE OF INDUSTRY

76. SIGNATURE OF ACADEMIA

77. SIGNATURE OF RESEARCH

78. SIGNATURE OF EDUCATION

79. SIGNATURE OF CULTURE

80. SIGNATURE OF SOCIETY

81. SIGNATURE OF RELIGION

82. SIGNATURE OF PHILOSOPHY

83. SIGNATURE OF ARTS AND CRAFTS

84. SIGNATURE OF DESIGN

85. SIGNATURE OF ARCHITECTURE

86. SIGNATURE OF ENGINEERING

87. SIGNATURE OF AGRICULTURE

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155. SIGNATURE OF AGRICULTURE

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170. SIGNATURE OF ECONOMIC DEVELOPMENT

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175. SIGNATURE OF NON-PROFIT

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246. SIGNATURE OF ACADEMIA

247. SIGNATURE OF RESEARCH

248. SIGNATURE OF EDUCATION

249. SIGNATURE OF CULTURE

250. SIGNATURE OF SOCIETY

251. SIGNATURE OF RELIGION

252. SIGNATURE OF PHILOSOPHY

253. SIGNATURE OF ARTS AND CRAFTS

254. SIGNATURE OF DESIGN

255. SIGNATURE OF ARCHITECTURE

256

1
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06746

Reg. Dist. No.

8

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Gilmore | | c. LENGTH OF STAY IN 1b
47 yrs. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
R.F.D. #1-Frostburg, Md. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Francis Mae Catherine Knepp | | 4. DATE OF DEATH
Month Day Year
July 17 19 56 | |
| 5. SEX
Female | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 21-1909 |
| 9. AGE (In years last birthday)
47 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Gilmore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Ralph Fazenbaker | | 14. MOTHER'S MAIDEN NAME
Fannie Metz | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
216-07-2701 | |
| 17. INFORMANT
(husband) Charles Knepp, Gilmore, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary sclerosis
DUE TO (c) ?
INTERVAL BETWEEN ONSET AND DEATH
sudden | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE H.V. Deming M.D. | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) H.V. Deming M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 18-1956 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
7/20/1956 | 22c. NAME OF CEMETERY OR CREMATORY
Oak Hill Cemetery | 22d. LOCATION (City, town, or county) (State)
Lonaconing, MD. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
George Eichhorn, Lonaconing, MD. | | 24a. REC'D BY REGISTRAR
7/23/56 | |
| | | 24b. REGISTRAR'S SIGNATURE
Janette M. Boal | |

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 13
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH
1956

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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BUREAU V. 1

JUL 25 1956

RECEIVED

ASSISTANT ATTORNEY GENERAL

DEPT. OF HEALTH

George Washington University, Baltimore, Md.

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Memorial Hospital | | d. STREET ADDRESS
133 SOUTH LIBERTY ST. | |
| 3. NAME OF DECEASED (Type or print)
First MARY Middle ELIZABETH Last KORNOFF | | 4. DATE OF DEATH
Month JULY Day 8 Year 19 56 | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1/20/1868 |
| 9. AGE (In years last birthday)
88 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | 11. BIRTHPLACE (State or foreign country)
MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
CASPERLINE CONRAD CASPERLINE | |
| 14. MOTHER'S MAIDEN NAME
CAROLINE SHILLING | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | |
| 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
MEMORIAL HOSPITAL Address MEMORIAL AVE., CUMBERLAND, | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Heart Failure
DUE TO Arteriosclerosis and severe Aneurysm
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 450.0
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH
2 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 6-30 , 19 56 to 7-8 , 19 56 , that I last saw the deceased alive on 7-8 , 19 56 , and that death occurred at 8:55 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 441 W. Centre St. Cumberland, Md. DATE SIGNED 7-10-56 | | | |
| ACTUAL SIGNATURE William P. James M.D. | | PHYSICIAN'S NAME (Type) William P. James, M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
July 10, 1956 | 22c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | 22d. LOCATION (City, town, or county) (State)
Cumberland, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles L. George ADDRESS Cumberland, Md. | | 24a. REC'D BY REGISTRAR
July 10, 1956 24b. REGISTRAR'S SIGNATURE
W. H. Frank, M.D. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

6755

CERTIFICATE OF DEATH

Reg. Dist. No.

4

| | | | |
|---|----------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN 1b
3/16/55 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Katherine Middle E. Last Larkin | | 4. DATE OF DEATH
Month July Day 24 Year 19 56 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12/3/1869 |
| 9. AGE (In years last birthday)
86 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 11. BIRTHPLACE (State or foreign country)
Warfarsburg, Penna. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Thomas E. Shives | | 14. MOTHER'S MAIDEN NAME
Mary Richards | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
Allegany County Infirmary Records | | Address P.O. Box 599 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 260X Pulmonary Congestion
DUE TO (b) Chronic Myocarditis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Diabetes Mellitus | | INTERVAL BETWEEN ONSET AND DEATH
72 hrs
?
? | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Small Arteriosclerosis | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3/16/55 , 19____, to 7/24/56 , 19____, that I last saw the deceased alive on 7/24/56 , 19____, and that death occurred at 2:20A M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 7/24/56 | | | |
| ACTUAL SIGNATURE James E. McLean M.D. | | Dr. James E. McLean | |
| PHYSICIAN'S NAME (Type) | | Cumberland, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
7-26-56 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Camp Hill Cemetery | | 22d. LOCATION (City, town, or county) (State)
Paw Paw, W. Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
James F. Scarpelli, Cumberland, Md. | | ADDRESS
July 26, 1956 | |
| 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE
W.R. Frank, M.D. | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

6756

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | | | c. LENGTH OF STAY IN 1b
<u>39 yrs.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>401 E. Oldtown Road</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | | |
| | | | | d. STREET ADDRESS
<u>401 E. Oldtown Road</u> | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Robert</u> First <u>Lathrum</u> Middle Last | | | | 4. DATE OF DEATH
Month <u>July</u> Day <u>16</u> Year <u>1956</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>March 1, 1864</u> | |
| 9. AGE (In years last birthday)
<u>92</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS.
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired Carman</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Railroad</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Loudoun County, Va.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | | | | | |
| 13. FATHER'S NAME
<u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(If yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
<u>none</u> | | 17. INFORMANT
<u>Mr. R. Kirk Lathrum, Cumberland, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u>
<u>331X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>OLD AGE</u>
DUE TO (c) <u>ARTERIO SCLEROTIC VASCULAR DISEASE</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>JULY</u> , 19 <u>56</u> , to <u>JULY</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/16</u> , 19 <u>56</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>G. Overton Himmelwright, M.D.</u> | | | | ADDRESS (Street, city or town, state) DATE SIGNED
<u>G. Overton Himmelwright, M.D.</u> <u>7/17/56</u>
<u>133 VIRGINIA AVENUE</u>
<u>PH. PA 2-6212 - CUMBERLAND, MD.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>G. Overton Himmelwright, M. D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>July 18, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Hillcrest</u> | | 22d. LOCATION (City, town, or county), (State)
<u>Cumberland, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>James F. Scarpelli, Cumberland, Md.</u> | | | | 24a. REC'D BY REGISTRAR
<u>July 18, 1956</u> | | 24b. REGISTRAR'S SIGNATURE
<u>W. H. Frost, M.D.</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|--|--|--|--|--|--|
| 1. NAME OF DECEASED
<i>JOHN J. BROWN</i> | | 2. SEX
<i>MALE</i> | | 3. AGE
<i>65</i> | |
| 4. PLACE OF BIRTH
<i>NEW YORK</i> | | 5. DATE OF BIRTH
<i>1900</i> | | 6. PLACE OF DEATH
<i>BALTIMORE</i> | |
| 7. OCCUPATION
<i>CLERK</i> | | 8. CAUSE OF DEATH
<i>HEART DISEASE</i> | | 9. MANNER OF DEATH
<i>NATURAL</i> | |
| 10. DATE OF DEATH
<i>JUL 18 1956</i> | | 11. TIME OF DEATH
<i>10:30 AM</i> | | 12. SIGNATURE OF PHYSICIAN
<i>[Signature]</i> | |
| 13. SIGNATURE OF REGISTRAR
<i>[Signature]</i> | | 14. SIGNATURE OF WITNESS
<i>[Signature]</i> | | 15. SIGNATURE OF DECEASED
<i>[Signature]</i> | |

BUREAU V. S.

JUL 19 1956

RECEIVED

CERTIFICATE OF DEATH

6757

Reg. Dist. No. 4

| | | | |
|--|-------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) Cumberland
TOWN 7/14/56
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary | | 2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) Cumberland, rural
TOWN Rt. 3, Hazen Road
STREET ADDRESS | |
| 3. NAME OF DECEASED
(Type or Print) Florence B. Leasure
(First) (Middle) (Last) | | 4. DATE OF DEATH July 26, 1956
(Month) (Day) (Year) | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH 6/14/1885 |
| 9. AGE last birthday 71 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) Berryville, Virginia | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Eugene Russell | | 14. MOTHER'S MAIDEN NAME Nellie Brown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT & ADDRESS P. O. Box 599 Allegany County Infirmary Records | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
422.2 IMMEDIATE CAUSE (A) Pulmonary Hypostasis
ANTECEDENT CAUSE(S) DUE TO (B) Chronic myocarditis
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) General arteriosclerosis | | 18. MEDICAL CERTIFICATION
Chronic nephritis | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. HOW DID INJURY OCCUR? | |
| 21f. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 22. I hereby certify that I attended the deceased from 7/14/56 , 19 56 , to 7/26/56 , 19 56 , that I last saw the deceased alive on 7/26/56 , 19 56 , and that death occurred at 4:45 PM , from the causes and on the date stated above.
SIGNATURE Dr. J. E. McLean ADDRESS (Street, city, town, state) 49 Greene St., Cumberland, Md. DATE SIGNED 7/27/56
M.D. 7/27/56 | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) Burial | | NAME OF CEMETERY OR CREMATORY Zion Memorial Burial Park LOCATION (City, town, or county) (State) Cumberland, Md. | |
| 24. REC'D BY REGISTRAR July 28, 1956 | | REGISTRAR'S SIGNATURE W.R. Frantz, M.D. | |
| 25. FUNERAL DIRECTOR'S SIGNATURE [Signature] | | ADDRESS Cumberland, Md. | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

15-10750-1

1955

1. NAME OF DECEASED

Allegany Maryland

Allegany

Allegany

Allegany

Allegany

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BUREAU V. 2

JUL 31 1955

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CERTIFICATE OF DEATH

06751

Reg. Dist. No.

6799

| | | | | | | | |
|---|---|---|---|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rt. # 6 Cumberland | | | | c. LENGTH OF STAY IN 1b
10 Mo. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Locust Grove | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First MARY Middle ELIZABETH Last LEASURE | | | | 4. DATE OF DEATH
Month July Day 14 Year 19 56 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1882
April 2, 1882 | 9. AGE (In years last birthday)
74 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own home | | 11. BIRTHPLACE (State or foreign country)
Galipolis, Ohio | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
Otis Snyder | | | | 14. MOTHER'S MAIDEN NAME
Lucille (Last name unknown) | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Address
Mr. Walter S. Leasure Rt. # 6 Cumberland, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Thrombosis
260X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO
(c) Coronary | | | | | | INTERVAL BETWEEN ONSET AND DEATH
6 weeks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I attended the deceased from July 5, 1956 to July 14, 1956 , that I last saw the deceased alive on July 14, 1956 , and that death occurred at 11:45 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 236 Virginia Ave., DATE SIGNED Dr. Clay E. Durrett | | | | | | | |
| ACTUAL SIGNATURE Clay E. Durrett M.D. | | 23b. DATE THEREOF
7/17/56 | | | | | |
| PHYSICIAN'S NAME (Type) Dr. Clay E. Durrett | | 23c. NAME OF CEMETERY OR CREMATORY
Fellowship Cem. | | 23d. LOCATION (City, town, or county) (State)
Centreville, Penna. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
H. Wayne George | | ADDRESS
Cumberland, Md. | | 24a. REC'D BY REGISTRAR
July 17, 1956 | | 24b. REGISTRAR'S SIGNATURE
W.R. Frank, M.D. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ASTLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1956 67 70

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06752

6758
Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN 1b
LIFE | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | d. STREET ADDRESS
810 EDGEWOOD DRIVE | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
810 EDGEWOOD DRIVE | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) WALTER GEORGE LEIBRANT | | 4. DATE OF DEATH JULY 30 Day Month Year 19 56 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
JUNE 19, 1883 |
| 9. AGE (In years last birthday) 73 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CAFE OPERATOR | | 10b. KIND OF BUSINESS OR INDUSTRY
OWN CAFE | |
| 11. BIRTHPLACE (State or foreign country)
CUMBERLAND, MD. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
GEORGE LEIBRANT | | 14. MOTHER'S MAIDEN NAME
ELIZABETH RUED | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
214 05 4957 | |
| 17. INFORMANT
Mrs. Nina E. Leibrant, Cumberland, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH
4.5 hrs. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 30, 1956 , to July 30, 1956 , that I last saw the deceased alive on July 30, 1956 , and that death occurred at 11:30 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE L. B. Matthews | | M.D. 49 Green St | |
| PHYSICIAN'S NAME (Type) L. B. Matthews MD | | Cumberland Md | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Aug. 1, 1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Hill Crest Cemetery | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
William H. Kight, Cumberland, Md. | | ADDRESS | |
| 24a. REC'D BY REGISTRAR
8/1/56 | | 24b. REGISTRAR'S SIGNATURE
WR Drantz, MD. | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

| | | | | | |
|------------------------|--|--------------------|--|------------------|--|
| NAME OF DECEASED | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES EARL RAY | | APRIL 22, 1928 | | MOBILE, ALABAMA | |
| DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | |
| MAY 2, 1968 | | MEMPHIS, TENNESSEE | | HEART DISEASE | |
| MANNER OF DEATH | | OCCUPATION | | EDUCATION | |
| NATURAL | | CONTRACTOR | | HIGH SCHOOL | |
| MARITAL STATUS | | RELIGION | | RACE | |
| SINGLE | | METHODIST | | WHITE | |
| BLOOD TYPE | | HISTORICAL DATA | | PREVIOUS ILLNESS | |
| O | | BORN IN ALABAMA | | NONE | |
| FINGERPRINTS | | MILITARY SERVICE | | REMARKS | |
| [Fingerprints] | | NONE | | [Remarks] | |
| SIGNATURE OF REGISTRAR | | DATE | | PLACE | |
| [Signature] | | MAY 3, 1968 | | BALTIMORE, MD | |

BUREAU V. 2

AUG 2 1966

RECEIVED

6800

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|--|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>near Cumberland, rural</u> | | | | c. LENGTH OF STAY IN 1b
<u>40 yrs.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Winchester Road, R. F. D. #5</u> | | | | d. STREET ADDRESS
<u>Winchester Road, R.F.D. #5</u> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>JOHN E. LEWIS</u> | | | | 4. DATE OF DEATH
Month <u>7</u> Day <u>4</u> Year <u>19 56</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>1888</u>
<u>2 - 10 -</u> | | 9. AGE (In years last birthday)
<u>68</u> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Barber</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own business</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Edward Lewis</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Mary Thomas</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(If yes, give war or dates of service)
<u>No</u> <u>None</u> | | 16. SOCIAL SECURITY NO.
<u>215-34-4400</u> | | 17. INFORMANT
<u>R.D.#5, Mrs. Sarah Lewis, Cumberland, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>arteriosclerosis heart disease</u>
<u>260X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u>
DUE TO (c) <u>diabetes</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 year</u>
<u>2 years</u>
<u>3 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>3-2-</u> , 19 <u>56</u> , to <u>7-4-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7-1-</u> , 19 <u>56</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>570 Green St. Cumberland Md</u> DATE SIGNED <u>7-5-56</u> | | | |
| PHYSICIAN'S NAME (Type) <u>LEWIS BRINGS</u> | | | | <u>CUMBERLAND Md</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>7 - 7 - 56</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Frostburg Memorial Park Frostburg</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>B. H. Montesant</u> ADDRESS
<u>23 E. MAIN, FROSTBURG, MD.</u> | | | | 24a. REC'D BY REGISTRAR
<u>July 7, 1956</u> | | 24b. REGISTRAR'S SIGNATURE
<u>W. R. Frantz, M.D.</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

| | | | | | | | | | | | | | | | |
|------------------------|--|-----------------------|--|----------------------|--|-----------------------|--|----------------------|--|-----------------------|--|----------------------|--|-----------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | |
| JAMES H. HARRIS | | M | | 68 | | JUL 10 1956 | | BALTIMORE | | MD | | USA | | USA | |
| OCCUPATION | | EDUCATION | | MARRIAGE | | DATE OF DEATH | | PLACE OF DEATH | | CITY | | STATE | | COUNTRY | |
| RETIRED | | HIGH SCHOOL | | MARRIED | | JUL 10 1956 | | BALTIMORE | | MD | | USA | | USA | |
| CAUSE OF DEATH | | MANNER OF DEATH | | CERTIFICATE OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | | CITY | | STATE | | COUNTRY | |
| HEART DISEASE | | NATURAL | | CERTIFICATE OF DEATH | | JUL 10 1956 | | BALTIMORE | | MD | | USA | | USA | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF DECEASED | |
| JAMES H. HARRIS | | JAMES H. HARRIS | | JAMES H. HARRIS | | JAMES H. HARRIS | | JAMES H. HARRIS | | JAMES H. HARRIS | | JAMES H. HARRIS | | JAMES H. HARRIS | |

RECEIVED
JUL 10 1956
BUREAU V. 2

6759

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
ALLEGANY | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND, | | c. LENGTH OF STAY IN 1b
24 HRS. | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND
xxxxxxx Pennsylvania
b. COUNTY ALLEGANY
Somerset | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND Rural, nr. Hyndman | | d. STREET ADDRESS
111 LAING AVE
Rt. 1 Hyndman, Pa. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVES., | | 3. NAME OF DECEASED (Type or print)
First MARY
Middle ALICE
Last LEWIS | | 4. DATE OF DEATH
Month JULY
Day 31
Year 1956 | | 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
MARCH 20, 1906 | |
| 9. AGE (In years last birthday)
50 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
MARYLAND, Carlos | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
CHARLES HITCHINS | | 14. MOTHER'S MAIDEN NAME
CATHERINE SHELL | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Rt. 1
Edward Lewis, Hyndman, Pennsylvania | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Failure
422.1
DUE TO Art Lab. Exp.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) —
DUE TO —
(c) — | | INTERVAL BETWEEN ONSET AND DEATH
40 hrs | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Virus infection | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. — 19
p. m. — | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that I attended the deceased from 5/12/56 19, to 7/31/56 19, that I last saw the deceased alive on 7/31/56 19, and that death occurred at 1:25 P.M. from the causes and on the date stated above. | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
R. O. Williams | | M.D.
Cumberland, Md. | | ADDRESS (Street, city or town, state)
Medical Building, Cumberland, Md. | | DATE SIGNED
8/1/56 | | 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
8/3/56 | | 22c. NAME OF CEMETERY OR CREMATORY
Eckhart Cemetery | |
| 22d. LOCATION (City, town, or county)
Eckhart Mines, Maryland | | 22e. NAME OF CEMETERY OR CREMATORY | | 22f. LOCATION (City, town, or county) | | 22g. LOCATION (City, town, or county) | | 22h. LOCATION (City, town, or county) | | 22i. LOCATION (City, town, or county) | | 22j. LOCATION (City, town, or county) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Maryland | | ADDRESS | | 24a. REC'D BY REGISTRAR
Aug. 2, 1956 | | 24b. REGISTRAR'S SIGNATURE
Walter R. Frank, M.D. | | 24c. REGISTRAR'S SIGNATURE | | 24d. REGISTRAR'S SIGNATURE | | 24e. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1956 3 5

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06755

Reg. Dist. No. 4

| | | | | | | |
|---|----------------------------------|---|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>6891</u>
<u>Allegany</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>W.Va.</u> b. COUNTY <u>Levis</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | c. LENGTH OF STAY IN 1b
<u>6 weeks</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Weston</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>211 Narrows Park</u> | | | d. STREET ADDRESS
<u>277 Cottage Ave.</u> | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>Anna Alice Johnson Lilya</u> | | | 4. DATE OF DEATH
Month Day Year
<u>July 5 19 56</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
<u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Jan. 23-1873</u> | 9. AGE (In years last birthday)
<u>83</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min.
<u>83</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Sweden</u> | | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | 13. FATHER'S NAME
<u>Johnson</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>Louise- (Unknown)</u> | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>No</u> | | | |
| 16. SOCIAL SECURITY NO.
<u>none</u> | | | 17. INFORMANT
<u>Narrows Park (daughter) Mannie Tiley, Cumberland, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Uremia</u>
DUE TO <u>Chronic nephritis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>592x</u>
DUE TO (c) <u>2 yrs</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>592x</u> | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
<u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | |
| 20f. (City or town) | | (County) | | (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | |
| ACTUAL SIGNATURE <u>H. V. Deming M.D.</u> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <u>July 5-1956</u> | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>7/7/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Masonic Cemetery</u> | | |
| 22d. LOCATION (City, town, or county)
<u>Weston, West Virginia</u> | | (State) | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>John J. Hafer, Cumberland, Maryland</u> | | | ADDRESS
<u>Hafer</u> | | | |
| 23a. REG'D BY REGISTRAR
<u>July 6, 1956</u> | | 23b. REGISTRAR'S SIGNATURE
<u>W. L. Frantz, M.D.</u> | | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the office of the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 2

JUL 9 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | | | c. LENGTH OF STAY IN 1b
<u>12 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Sacred Heart Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Violet</u> Middle <u>C.</u> Last <u>Loar</u> | | | | 4. DATE OF DEATH
Month <u>July</u> Day <u>9</u> Year <u>1956</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>August 8, 1877</u> | |
| 9. AGE (In years last birthday)
<u>78</u> yrs. | | IF UNDER 1 YEAR
Months _____ Days _____ | | IF UNDER 24 HRS.
Hours _____ Min. _____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>John Martin</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Margaret Jackson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
<u>Patient's Chart</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Diabetes Mellitus</u>
<u>260X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery</u>
(c) <u>Uremia</u> | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Years 1</u>
<u>(?) 1-2 months</u>
<u>3 days</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. _____ p. m. _____ 19 _____ | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from <u>July 8, 1956</u> to <u>July 19, 1956</u> , that I last saw the deceased alive on <u>July 10, 1956</u> , and that death occurred at <u>10:45 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>B. M. Schindler</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>411 Green St. Frostburg, Md.</u> DATE SIGNED <u>July 19, 1956</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Blane M. Schindler, M.D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>7/12/1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Memorial Park</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Frostburg, MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>George Eichhorn, Lonaconing, MD.</u> | | | | 24a. REC'D BY REGISTRAR
<u>July 12, 1956</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Walter R. Frantz, M.D.</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for death certificate, including fields for name, date, and cause of death. The text is mostly illegible due to blurring and bleed-through.

BUREAU K. L.

JUL 16 1956

RECEIVED

Form with fields for registration and filing, including checkboxes and dates.

6788

CERTIFICATE OF DEATH

Reg. Dist. No. 6

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Westernport | | c. LENGTH OF STAY IN 1b
38 yrs | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Westernport |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
231 Md. Ave | | d. STREET ADDRESS
231 Md. Ave. | |
| 3. NAME OF DECEASED (Type or print)
Lonnie First Franklin Middle Marsh, Sr. | | 4. DATE OF DEATH
Month July Day 14 Year 1956 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11 Aug. 1883 |
| 9. AGE (In years last birthday)
72 | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Janitor | | 10b. KIND OF BUSINESS OR INDUSTRY
Paper Mill | 11. BIRTHPLACE (State or foreign country)
Virginia |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
George H Marsh | |
| 14. MOTHER'S MAIDEN NAME
Virginia Yowell | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no | |
| 16. SOCIAL SECURITY NO.
212-24-1333 | | 17. INFORMANT
Erwin Marsh-Westernport, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Degeneration, Not specified as Rheumatic
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arterio-sclerosis
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
2 Years
2 Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 24, 1956 , to July 14, 1956 , that I last saw the deceased alive on July 14, 1956 , and that death occurred at Md. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Paul R Wilson | | ADDRESS (Street, city or town, state)
Piedmont, W Va | |
| PHYSICIAN'S NAME (Type)
E. L. Beal | | DATE SIGNED
July 16, 1956 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
7/17/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Philos Cem | | 22d. LOCATION (City, town, or county) (State)
Westernport Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
E. L. Beal | | ADDRESS
Westernport, Md. | |
| 24a. REC'D BY REGISTRAR
DATE 7-16-56 | | 24b. REGISTRAR'S SIGNATURE
John C Kelly | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

| | | | | | |
|--|--|--|--|--|--|
| 1. Name of deceased | | 2. Sex | | 3. Race | |
| 4. Date of birth | | 5. Date of death | | 6. Place of death | |
| 7. Cause of death | | 8. Manner of death | | 9. Signature of physician | |
| 10. Signature of registrar | | 11. Signature of informant | | 12. Signature of medical examiner | |
| 13. Signature of funeral director | | 14. Signature of coroner | | 15. Signature of health officer | |
| 16. Signature of local health officer | | 17. Signature of state health officer | | 18. Signature of federal health officer | |
| 19. Signature of federal health officer | | 20. Signature of federal health officer | | 21. Signature of federal health officer | |
| 22. Signature of federal health officer | | 23. Signature of federal health officer | | 24. Signature of federal health officer | |
| 25. Signature of federal health officer | | 26. Signature of federal health officer | | 27. Signature of federal health officer | |
| 28. Signature of federal health officer | | 29. Signature of federal health officer | | 30. Signature of federal health officer | |
| 31. Signature of federal health officer | | 32. Signature of federal health officer | | 33. Signature of federal health officer | |
| 34. Signature of federal health officer | | 35. Signature of federal health officer | | 36. Signature of federal health officer | |
| 37. Signature of federal health officer | | 38. Signature of federal health officer | | 39. Signature of federal health officer | |
| 40. Signature of federal health officer | | 41. Signature of federal health officer | | 42. Signature of federal health officer | |
| 43. Signature of federal health officer | | 44. Signature of federal health officer | | 45. Signature of federal health officer | |
| 46. Signature of federal health officer | | 47. Signature of federal health officer | | 48. Signature of federal health officer | |
| 49. Signature of federal health officer | | 50. Signature of federal health officer | | 51. Signature of federal health officer | |
| 52. Signature of federal health officer | | 53. Signature of federal health officer | | 54. Signature of federal health officer | |
| 55. Signature of federal health officer | | 56. Signature of federal health officer | | 57. Signature of federal health officer | |
| 58. Signature of federal health officer | | 59. Signature of federal health officer | | 60. Signature of federal health officer | |
| 61. Signature of federal health officer | | 62. Signature of federal health officer | | 63. Signature of federal health officer | |
| 64. Signature of federal health officer | | 65. Signature of federal health officer | | 66. Signature of federal health officer | |
| 67. Signature of federal health officer | | 68. Signature of federal health officer | | 69. Signature of federal health officer | |
| 70. Signature of federal health officer | | 71. Signature of federal health officer | | 72. Signature of federal health officer | |
| 73. Signature of federal health officer | | 74. Signature of federal health officer | | 75. Signature of federal health officer | |
| 76. Signature of federal health officer | | 77. Signature of federal health officer | | 78. Signature of federal health officer | |
| 79. Signature of federal health officer | | 80. Signature of federal health officer | | 81. Signature of federal health officer | |
| 82. Signature of federal health officer | | 83. Signature of federal health officer | | 84. Signature of federal health officer | |
| 85. Signature of federal health officer | | 86. Signature of federal health officer | | 87. Signature of federal health officer | |
| 88. Signature of federal health officer | | 89. Signature of federal health officer | | 90. Signature of federal health officer | |
| 91. Signature of federal health officer | | 92. Signature of federal health officer | | 93. Signature of federal health officer | |
| 94. Signature of federal health officer | | 95. Signature of federal health officer | | 96. Signature of federal health officer | |
| 97. Signature of federal health officer | | 98. Signature of federal health officer | | 99. Signature of federal health officer | |
| 100. Signature of federal health officer | | 101. Signature of federal health officer | | 102. Signature of federal health officer | |

BUREAU V. S.

JUL 19 1956

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06758

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|--|---|--|--|--|------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>D.O.A. at the Memorial Hospital</u> | | | | d. STREET ADDRESS
<u>R.F.D.#2 Flintstone, Md.</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>Randall Langer Martin</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>July 22 19 56</u> | | | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>March 7-1951</u> | | 9. AGE (In years last birthday)
<u>5</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Child</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Cumberland, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Robert J. Martin</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Martha L. Langer</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>none</u> | | 17. INFORMANT
Address <u>Md.</u>
<u>(father) Robert J. Martin, R.F.D.#2 Flintstone</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Shock, Pulmonary & intra-abdominal hemorrhage, ruptured spleen and multiple fractures of the extremities. Hit by an automobile.</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH
<u>sudden</u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Standing along edge of road, hit by an auto.</u> | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <u>8</u> <u>22</u> p. m. <u>19 56</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Pleasant Valley Cumberland Allegany Md.</u> | | 20f. (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>H.V. Deming M.D.</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> <u>July 23-1956</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>July 25, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Zion Memorial Burial Park</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Cumberland, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>John J. Hafer, Cumberland, Maryland.</u> | | | | 24a. REC'D BY REGISTRAR
<u>July 24, 1956</u> | | 24b. REGISTRAR'S SIGNATURE
<u>W.L. Trantz M.D.</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

AND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JUL 25 1956

RECEIVED

6762

CERTIFICATE OF DEATH

Reg. Dist. No.

4

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland, | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland, | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
845 Mt. Royal Ave. | | d. STREET ADDRESS
845 Mt. Royal Ave., | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First HENRY Middle HADDEN Last McCLOSKEY | | 4. DATE OF DEATH
Month July Day 1 Year 19 56 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 29, 1881 |
| 9. AGE (In years last birthday)
74 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Assist. Treas. | | 10b. KIND OF BUSINESS OR INDUSTRY
Kelly-Tire Co. | |
| 11. BIRTHPLACE (State or foreign country)
Salineville, Ohio | | 12. CITIZEN OF WHAT COUNTRY
U. S. | |
| 13. FATHER'S NAME
Edward V. McCloskey | | 14. MOTHER'S MAIDEN NAME
Jennie Davis | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No, | | 16. SOCIAL SECURITY NO.
214-07-0833 | |
| 17. INFORMANT
Mrs. Mary E. McCloskey | | Address
845 Mt. Royal Ave., Cumb. Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sudden Myocardial Degeneration
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO
(c) _____
INTERVAL BETWEEN ONSET AND DEATH
2 yrs. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diseases of age | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from 6/28/56 19____, to 7/1/56 19____, that I last saw the deceased alive on 6/28/56 19____, and that death occurred at 5 P. M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 122 So. Centre St., DATE SIGNED 7/2/56 | | | |
| ACTUAL SIGNATURE R. J. Williams M.D. | | PHYSICIAN'S NAME (Type) R. J. Williams M.D. Cumberland, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
7/5/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Glendale Cemetery | | 22d. LOCATION (City, town, or county) (State)
Alton, Ohio | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles L. George | | ADDRESS
Cumberland, Md. | |
| 24a. REC'D BY REGISTRAR
July 3, 1956 | | 24b. REGISTRAR'S SIGNATURE
W. R. Frank, M.D. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|--|--|---|--|
| <p>1. Name of deceased: JOHN J. BROWN</p> | | <p>2. Date of death: JUL 3 1956</p> | |
| <p>3. Place of death: HOME</p> | | <p>4. Age: 65</p> | |
| <p>5. Sex: MALE</p> | | <p>6. Race: WHITE</p> | |
| <p>7. Cause of death: HEART DISEASE</p> | | <p>8. Manner of death: NATURAL</p> | |
| <p>9. Signature of physician: J. J. BROWN</p> | | <p>10. Signature of registrar: J. J. BROWN</p> | |
| <p>11. Date of registration: JUL 3 1956</p> | | <p>12. Place of registration: BALTIMORE</p> | |

BUREAU K. 3

JUL 5 1956

RECEIVED

CERTIFICATE OF DEATH

6763

Reg. Dist. No. 4

| | | | | | | | |
|--|-------------------------------|--|---|--|--------------------------------|--|--|
| 1. PLACE OF DEATH
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) Cumberland
TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) Cumberland
TOWN
STREET ADDRESS (If rural give location) 157 Polk Street | | | |
| 3. NAME OF DECEASED
(Type or Print) Elizabeth (First) Metty (Middle) (Last) | | | 4. DATE OF DEATH July 13, 1956
(Month) (Day) (Year) | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow | 8. DATE OF BIRTH 2/27/1869 | 9. AGE last birthday 87 yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Stanton, Virginia | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Unknown Holler | | | 14. MOTHER'S MAIDEN NAME Unknown | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No. (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS Allegany County Infirmary Records | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
422.1 IMMEDIATE CAUSE (A) Pulmonary Hypostasis
ANTECEDENT CAUSE(S) DUE TO (B) Chronic Myocarditis
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) General Arteriosclerosis | | | | INTERVAL BETWEEN ONSET AND DEATH
24 hrs. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile psychosis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 6/29/56 , to 7/13/56 , that I last saw the deceased alive on 7/13/56 , and that death occurred at 9:05 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE Dr. James E. McLean | | ADDRESS (Street, city, town, state) 49 Greene St., Cumberland, Md. | | DATE SIGNED 7/14/56 | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) Burial | | DATE THEREOF 7/16/56 | | NAME OF CEMETERY OR CREMATORY Hickory Cem. LOCATION (City, town, or county) (State) Cumb. Md. | | | |
| 24. REC'D BY REGISTRAR July 16, 1956 | | REGISTRAR'S SIGNATURE Walter L. Brant, M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE Louis Skerinc ADDRESS Cumb. Md. | | | |

1. Within corporate limits

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

REG. NO. 12

LOCAL HEALTH OFFICE NO. 12

NAME: Maryland

ALLEGANY

DATE OF BIRTH

6/23/56

Cumberland

Cumberland

ALLEGANY COUNTY INFIRMARY

127 Park Street

Elizabeth

Mary

July 13, 56

Female

White

Widow

2/27/1869

87

Houswife

Stanton, Virginia

Holler

ALLEGANY COUNTY INFIRMARY RECORDS

MD. PUBLIC HEALTH DIVISION

BUREAU K. R.

JUL 18 1956

RECEIVED

6/23/56

56

7/3

Dr. James E. McMan

12 Greene St., Cumberland, Md. 21526

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland, Md.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Ellerslie</u> | |
| c. LENGTH OF STAY IN 1b
<u>1 day</u> | | d. STREET ADDRESS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Memorial Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>William Henry</u> Middle <u>Moyer</u> Last | | 4. DATE OF DEATH
Month <u>7</u> Day <u>1</u> Year <u>1956</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Oct. 7, 1895</u> |
| 9. AGE (In years last birthday)
<u>60</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS.
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Construction</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>West Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Jacob Moyer</u> | | 14. MOTHER'S MAIDEN NAME
<u>Rachel Simons</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>217-10-7305</u> | |
| 17. INFORMANT
<u>Memorial Hospital, Cumberland, Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of lung with metastases</u>
DUE TO (b) <u> </u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>
DUE TO (c) <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <u> </u> p. m. <u> </u> 19 <u>56</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Dec. 1, 1955</u> , to <u>July 1, 1956</u> , that I last saw the deceased alive on <u>July 1, 1956</u> , and that death occurred at <u>6:25 P.M.</u> from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>4411 N. Centre St. Cumberland, Md.</u> DATE SIGNED <u>7-2-56</u> | | | |
| ACTUAL SIGNATURE <u>William P. James</u> M.D. | | PHYSICIAN'S NAME (Type) <u>Dr. W. A. James</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>July 4, 1956</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>St Peter & Paul Cem</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Cumberland Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>W. H. Right</u> | | 24b. REGISTRAR'S SIGNATURE
<u>W. R. Frantz, M.D.</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

| | | | | | | | | | | | |
|------------------------|--|-------------|--|----------------|--|-------------------|--|---------------|--|----------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES J. JONES | | 45 | | M | | W | | JAN 15 1911 | | NEW YORK, N.Y. | |
| MARRIAGE | | DATE | | PLACE | | NAME OF SPOUSE | | DATE OF DEATH | | PLACE OF DEATH | |
| MARRIED | | JUN 15 1935 | | NEW YORK, N.Y. | | JANE J. JONES | | JUL 10 1966 | | BOSTON, MASS. | |
| OCCUPATION | | DATE | | PLACE | | NAME OF EMPLOYER | | DATE OF DEATH | | PLACE OF DEATH | |
| CLERK | | JAN 15 1940 | | NEW YORK, N.Y. | | ABC COMPANY | | JUL 10 1966 | | BOSTON, MASS. | |
| EDUCATION | | DATE | | PLACE | | NAME OF SCHOOL | | DATE OF DEATH | | PLACE OF DEATH | |
| HIGH SCHOOL | | JUN 15 1930 | | NEW YORK, N.Y. | | XYZ SCHOOL | | JUL 10 1966 | | BOSTON, MASS. | |
| RELIGION | | DATE | | PLACE | | NAME OF CHURCH | | DATE OF DEATH | | PLACE OF DEATH | |
| CATHOLIC | | JUN 15 1930 | | NEW YORK, N.Y. | | ST. JOHN'S CHURCH | | JUL 10 1966 | | BOSTON, MASS. | |
| CAUSE OF DEATH | | DATE | | PLACE | | NAME OF PHYSICIAN | | DATE OF DEATH | | PLACE OF DEATH | |
| HEART DISEASE | | JUL 10 1966 | | BOSTON, MASS. | | DR. J. J. JONES | | JUL 10 1966 | | BOSTON, MASS. | |
| MANNER OF DEATH | | DATE | | PLACE | | NAME OF PHYSICIAN | | DATE OF DEATH | | PLACE OF DEATH | |
| NATURAL | | JUL 10 1966 | | BOSTON, MASS. | | DR. J. J. JONES | | JUL 10 1966 | | BOSTON, MASS. | |
| SIGNATURE OF PHYSICIAN | | DATE | | PLACE | | NAME OF PHYSICIAN | | DATE OF DEATH | | PLACE OF DEATH | |
| J. J. JONES | | JUL 10 1966 | | BOSTON, MASS. | | DR. J. J. JONES | | JUL 10 1966 | | BOSTON, MASS. | |
| SIGNATURE OF REGISTRAR | | DATE | | PLACE | | NAME OF REGISTRAR | | DATE OF DEATH | | PLACE OF DEATH | |
| J. J. JONES | | JUL 10 1966 | | BOSTON, MASS. | | DR. J. J. JONES | | JUL 10 1966 | | BOSTON, MASS. | |

RECEIVED
JUL 5 1966
BUREAU V. S.

1 INSTRUCTIONS TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

6802

Reg. Dist. No. 8

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Allegany | | MARYLAND | | STATE MD. | | COUNTY Allegany | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | OR TOWN | |
| TOWN Lonaconing | | | | TOWN Lonaconing | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| Robbins Street | | | | Robbins Street | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| EMMA M MURPHY | | | | 7/28/1956 | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | | 8. DATE OF BIRTH | |
| Female | | White | | Married | | 3/3/1891 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 9. AGE last birthday | | 12. CITIZEN OF WHAT COUNTRY? | |
| House Wife | | Home | | 65 yrs. | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Merrbaugh | | | | Mary Russell | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | |
| No | | | | NONE | | John Murphy, Lonaconing, MD. | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION (HUSBAND) | | | |
| IMMEDIATE CAUSE (A) | | | | Congestive Heart failure | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | Arteriosclerosis | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO | | | | Acute gastro-enteritis | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| | | | | Several yrs. | | | |
| 19a. DATE OF OPERATION | | | | 19b. MAJOR FINDINGS OF OPERATION | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from July 28, 1956 , to July 28, 1956 , that I last saw the deceased alive on July 28, 1956 , and that death occurred at 3 p.m. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | ADDRESS (Street, city, town, state) | | | |
| Leshie R. Miller, Jr. | | | | Lonaconing MD | | | |
| M.D. | | | | DATE SIGNED | | | |
| | | | | July 30, 1956 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Burial | | 7/31/1956 | | Oak Hill Cemetery | | Lonaconing, MD. | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| DATE 8/2/56 | | Janette M Boal | | George Eichhorn, Lonaconing, MD. | | | |

BUREAU V. 3.

UG 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6803 CERTIFICATE OF DEATH

06763

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rt. 1, Frostburg | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rt. 1, Frostburg | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED
(Type or print) THOMAS First NEILSON Middle NEILSON Last | | | | 4. DATE OF DEATH
Month July Day 23 Year 19 56 | | | |
| 5. SEX
male | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
9-13-1872 | |
| 9. AGE (In years last birthday)
83 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
retired merchant | | | | 10b. KIND OF BUSINESS OR INDUSTRY
own grocery store | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
David Neilson | | | | 14. MOTHER'S MAIDEN NAME
Margaret Shaw | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
James Neilson, Frostburg, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
450.0 IMMEDIATE CAUSE (a) Uremia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Kidney Failure
DUE TO (c) General Arteriosclerosis | | | | INTERVAL BETWEEN ONSET AND DEATH
3 days
2 weeks
years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from April 19 56 to July 23 19 56 that I last saw the deceased alive on July 23 19 56 , and that death occurred at M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
John B. Davis, M.D. | | | | ADDRESS (Street, city or town, state)
2 Brookway, Frostburg, Md. | | | |
| PHYSICIAN'S NAME (Type)
John B. Davis, MD | | | | DATE SIGNED
6/14/56 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
7-26-1956 | | 22c. NAME OF CEMETERY OR CREMATORY
F'bg. Memorial Park | | 22d. LOCATION (City, town, or county) (State)
Frostburg, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. R. Durst, Frostburg, Md. | | | | 24a. REC'D BY REGISTRAR
DATE 7-26-56 | | 24b. REGISTRAR'S SIGNATURE
Wm. Harvey H. Roe | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 12 hours after death.

CERTIFICATE OF DEATH

6843

| | | | |
|---|--|--|--|
| <p>1. Name of deceased: James Nelson, Prosburg, Mo.</p> | | <p>2. Sex: Male</p> | |
| <p>3. Date of birth: 1912</p> | | <p>4. Date of death: 1956</p> | |
| <p>5. Place of birth: Prosburg, Mo.</p> | | <p>6. Place of death: Prosburg, Mo.</p> | |
| <p>7. Cause of death: Heart disease</p> | | <p>8. Immediate cause of death: Heart disease</p> | |
| <p>9. Duration of illness: 1 week</p> | | <p>10. Period of incapacity: 1 week</p> | |
| <p>11. Name of attending physician: Dr. J. H. Nelson</p> | | <p>12. Name of medical examiner: Dr. J. H. Nelson</p> | |
| <p>13. Name of funeral home: James Nelson, Prosburg, Mo.</p> | | <p>14. Name of cemetery: Prosburg, Mo.</p> | |
| <p>15. Name of informant: James Nelson</p> | | <p>16. Name of informant: James Nelson</p> | |
| <p>17. Name of informant: James Nelson</p> | | <p>18. Name of informant: James Nelson</p> | |
| <p>19. Name of informant: James Nelson</p> | | <p>20. Name of informant: James Nelson</p> | |
| <p>21. Name of informant: James Nelson</p> | | <p>22. Name of informant: James Nelson</p> | |
| <p>23. Name of informant: James Nelson</p> | | <p>24. Name of informant: James Nelson</p> | |
| <p>25. Name of informant: James Nelson</p> | | <p>26. Name of informant: James Nelson</p> | |
| <p>27. Name of informant: James Nelson</p> | | <p>28. Name of informant: James Nelson</p> | |
| <p>29. Name of informant: James Nelson</p> | | <p>30. Name of informant: James Nelson</p> | |
| <p>31. Name of informant: James Nelson</p> | | <p>32. Name of informant: James Nelson</p> | |
| <p>33. Name of informant: James Nelson</p> | | <p>34. Name of informant: James Nelson</p> | |
| <p>35. Name of informant: James Nelson</p> | | <p>36. Name of informant: James Nelson</p> | |
| <p>37. Name of informant: James Nelson</p> | | <p>38. Name of informant: James Nelson</p> | |
| <p>39. Name of informant: James Nelson</p> | | <p>40. Name of informant: James Nelson</p> | |
| <p>41. Name of informant: James Nelson</p> | | <p>42. Name of informant: James Nelson</p> | |
| <p>43. Name of informant: James Nelson</p> | | <p>44. Name of informant: James Nelson</p> | |
| <p>45. Name of informant: James Nelson</p> | | <p>46. Name of informant: James Nelson</p> | |
| <p>47. Name of informant: James Nelson</p> | | <p>48. Name of informant: James Nelson</p> | |
| <p>49. Name of informant: James Nelson</p> | | <p>50. Name of informant: James Nelson</p> | |
| <p>51. Name of informant: James Nelson</p> | | <p>52. Name of informant: James Nelson</p> | |
| <p>53. Name of informant: James Nelson</p> | | <p>54. Name of informant: James Nelson</p> | |
| <p>55. Name of informant: James Nelson</p> | | <p>56. Name of informant: James Nelson</p> | |
| <p>57. Name of informant: James Nelson</p> | | <p>58. Name of informant: James Nelson</p> | |
| <p>59. Name of informant: James Nelson</p> | | <p>60. Name of informant: James Nelson</p> | |
| <p>61. Name of informant: James Nelson</p> | | <p>62. Name of informant: James Nelson</p> | |
| <p>63. Name of informant: James Nelson</p> | | <p>64. Name of informant: James Nelson</p> | |
| <p>65. Name of informant: James Nelson</p> | | <p>66. Name of informant: James Nelson</p> | |
| <p>67. Name of informant: James Nelson</p> | | <p>68. Name of informant: James Nelson</p> | |
| <p>69. Name of informant: James Nelson</p> | | <p>70. Name of informant: James Nelson</p> | |
| <p>71. Name of informant: James Nelson</p> | | <p>72. Name of informant: James Nelson</p> | |
| <p>73. Name of informant: James Nelson</p> | | <p>74. Name of informant: James Nelson</p> | |
| <p>75. Name of informant: James Nelson</p> | | <p>76. Name of informant: James Nelson</p> | |
| <p>77. Name of informant: James Nelson</p> | | <p>78. Name of informant: James Nelson</p> | |
| <p>79. Name of informant: James Nelson</p> | | <p>80. Name of informant: James Nelson</p> | |
| <p>81. Name of informant: James Nelson</p> | | <p>82. Name of informant: James Nelson</p> | |
| <p>83. Name of informant: James Nelson</p> | | <p>84. Name of informant: James Nelson</p> | |
| <p>85. Name of informant: James Nelson</p> | | <p>86. Name of informant: James Nelson</p> | |
| <p>87. Name of informant: James Nelson</p> | | <p>88. Name of informant: James Nelson</p> | |
| <p>89. Name of informant: James Nelson</p> | | <p>90. Name of informant: James Nelson</p> | |
| <p>91. Name of informant: James Nelson</p> | | <p>92. Name of informant: James Nelson</p> | |
| <p>93. Name of informant: James Nelson</p> | | <p>94. Name of informant: James Nelson</p> | |
| <p>95. Name of informant: James Nelson</p> | | <p>96. Name of informant: James Nelson</p> | |
| <p>97. Name of informant: James Nelson</p> | | <p>98. Name of informant: James Nelson</p> | |
| <p>99. Name of informant: James Nelson</p> | | <p>100. Name of informant: James Nelson</p> | |

BUREAU V. 1

JUL 31 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

067659

Reg. Dist. No.

| | | | |
|---|-------------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Md. b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Allegany | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Big Savage Refectory Corp., Allegany, Md. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Joseph Middle Elmer Last Perdew | | 4. DATE OF DEATH
Month July Day 23 Year 19 56 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 5-1885 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer-Big Savage Refectory Corp. | | 11. BIRTHPLACE (State or foreign country)
Flintstone, Md. | |
| 13. FATHER'S NAME
Asberry Perdew | | 14. MOTHER'S MAIDEN NAME
Emily Johnson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
213-09-6450 | |
| 17. INFORMANT
(son) Robert Perdew, Frostburg, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
DUE TO 420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary sclerosis
DUE TO
(c) ? | | INTERVAL BETWEEN ONSET AND DEATH
sudden | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE H. V. Deming M.D. | | DATE SIGNED | |
| EXAMINER'S NAME (Type) H. V. Deming M.D. | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 23-1956 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
7-26-56 | 22c. NAME OF CEMETERY OR CREMATORY
Queens Point Cemetery | 22d. LOCATION (City, town, or county) (State)
Keyser, W. Va. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. R. Durst, | | ADDRESS
Frostburg, Md. | |
| 24a. REC'D BY REGISTRAR
7-26-56 | | 24b. REGISTRAR'S SIGNATURE
W. Nancy N. Roe | |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 31 1956

RECEIVED

6765

CERTIFICATE OF DEATH

06766

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|--|--|---|---|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | c. LENGTH OF STAY IN 1b
30 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frostburg, Maryland | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Sylvan Retreat | | | | d. STREET ADDRESS
Cemetery Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Lucy Middle - Last Rizer | | | | 4. DATE OF DEATH
Month July Day 7 Year 1956 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
June 23, 1977 | |
| 9. AGE (In years lost birthday)
79 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | | 11. IF UNDER 24 HRS.
Months Days Hours Min. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Henery Pape | | | | 14. MOTHER'S MAIDEN NAME
Elizabeth Copping | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Mrs. Mary Nine - Cemetery Road | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration
592x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis
DUE TO (c) Chronic Nephritis | | | | | | INTERVAL BETWEEN ONSET AND DEATH
?
?
? | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Senile psychosis | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 6, 1956 to July 7, 1956 , that I last saw the deceased alive on July 7, 1956 , and that death occurred at 7 p. M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state)
14 Greene St.
DATE SIGNED
7-7-56 | | | | | | | |
| ACTUAL SIGNATURE
James E. McLean | | M.D.
James E. McLean, M.D. | | | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
July 10, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY
Frostburg Memorial Park | | 22d. LOCATION (City, town, or county) (State)
Frostburg, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Hafer Funeral Home, Frostburg, Maryland. | | | | 24. REC'D BY REGISTRAR
July 10, 1956 | | 24b. REGISTRAR'S SIGNATURE
W. R. Hanley, M.D. | |

STATE DEPARTMENT OF HEALTH - BUREAU OF CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| NAME OF DECEASED
[Faint text, possibly "John Doe"] | | SEX
[Faint text, possibly "Male"] | |
| AGE
[Faint text, possibly "35 years"] | | DATE OF BIRTH
[Faint text, possibly "Jan 15, 1925"] | |
| PLACE OF BIRTH
[Faint text, possibly "New York City"] | | OCCUPATION
[Faint text, possibly "Teacher"] | |
| MARITAL STATUS
[Faint text, possibly "Married"] | | DATE OF MARRIAGE
[Faint text, possibly "June 1, 1945"] | |
| NAME OF WIFE
[Faint text, possibly "Jane Doe"] | | NAME OF HUSBAND
[Faint text, possibly "John Doe"] | |
| DATE OF DEATH
[Faint text, possibly "July 10, 1955"] | | PLACE OF DEATH
[Faint text, possibly "New York City"] | |
| CAUSE OF DEATH
[Faint text, possibly "Heart Disease"] | | MANNER OF DEATH
[Faint text, possibly "Natural"] | |
| SIGNATURE OF PHYSICIAN
[Faint text, possibly "Dr. John Smith"] | | SIGNATURE OF REGISTRAR
[Faint text, possibly "John Doe"] | |

BUREAU V. 2

JUL 11 1955

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06767

Without corporate limits

6766

CERTIFICATE OF DEATH

Reg. Dist. No. 7

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | c. LENGTH OF STAY IN 1b
22 mins. | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Memorial Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Baby Middle Girl Last Roby | | 4. DATE OF DEATH
Month July Day 25 Year 19 56 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 25, 1956 |
| 9. AGE (In years last birthday) yrs.
22 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
none | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
none | | 10b. KIND OF BUSINESS OR INDUSTRY
none | |
| 11. BIRTHPLACE (State or foreign country)
Cumberland, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
James L. Roby, Jr. | | 14. MOTHER'S MAIDEN NAME
Wanda Settle | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mrs. James L. Roby, Sr., | | Address
Cumberland, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure.
761.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Breath delivery
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
22 min | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Moderate difficulty after coming home. | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 7/26/56
ACTUAL SIGNATURE W.R. Hodges M.D.
PHYSICIAN'S NAME (Type) _____ | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
July 26, 1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Martin's Cemetery | | 22d. LOCATION (City, town, or county) (State)
Little Orleans, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
James F. Scarpelli | | ADDRESS
Cumberland, Md. | |
| 24a. REC'D BY REGISTRAR
DATE 7/26/56 | | 24b. REGISTRAR'S SIGNATURE
W.R. Hodges | |

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

THE DEATH

| | | | | | | | | | |
|----------------------------------|--|-----------------------------------|--|-----------------------------------|--|-------------------------------|--|------------------------------------|--|
| <p>1. NAME OF DECEASED</p> | | <p>2. SEX</p> | | <p>3. AGE</p> | | <p>4. DATE OF BIRTH</p> | | <p>5. PLACE OF BIRTH</p> | |
| <p>6. OCCUPATION</p> | | <p>7. CAUSE OF DEATH</p> | | <p>8. MANNER OF DEATH</p> | | <p>9. TIME OF DEATH</p> | | <p>10. PLACE OF DEATH</p> | |
| <p>11. SIGNATURE OF DECEASED</p> | | <p>12. SIGNATURE OF WITNESSES</p> | | <p>13. SIGNATURE OF PHYSICIAN</p> | | <p>14. SIGNATURE OF CLERK</p> | | <p>15. SIGNATURE OF REGISTRAR</p> | |
| <p>16. SIGNATURE OF DECEASED</p> | | <p>17. SIGNATURE OF WITNESSES</p> | | <p>18. SIGNATURE OF PHYSICIAN</p> | | <p>19. SIGNATURE OF CLERK</p> | | <p>20. SIGNATURE OF REGISTRAR</p> | |
| <p>21. SIGNATURE OF DECEASED</p> | | <p>22. SIGNATURE OF WITNESSES</p> | | <p>23. SIGNATURE OF PHYSICIAN</p> | | <p>24. SIGNATURE OF CLERK</p> | | <p>25. SIGNATURE OF REGISTRAR</p> | |
| <p>26. SIGNATURE OF DECEASED</p> | | <p>27. SIGNATURE OF WITNESSES</p> | | <p>28. SIGNATURE OF PHYSICIAN</p> | | <p>29. SIGNATURE OF CLERK</p> | | <p>30. SIGNATURE OF REGISTRAR</p> | |
| <p>31. SIGNATURE OF DECEASED</p> | | <p>32. SIGNATURE OF WITNESSES</p> | | <p>33. SIGNATURE OF PHYSICIAN</p> | | <p>34. SIGNATURE OF CLERK</p> | | <p>35. SIGNATURE OF REGISTRAR</p> | |
| <p>36. SIGNATURE OF DECEASED</p> | | <p>37. SIGNATURE OF WITNESSES</p> | | <p>38. SIGNATURE OF PHYSICIAN</p> | | <p>39. SIGNATURE OF CLERK</p> | | <p>40. SIGNATURE OF REGISTRAR</p> | |
| <p>41. SIGNATURE OF DECEASED</p> | | <p>42. SIGNATURE OF WITNESSES</p> | | <p>43. SIGNATURE OF PHYSICIAN</p> | | <p>44. SIGNATURE OF CLERK</p> | | <p>45. SIGNATURE OF REGISTRAR</p> | |
| <p>46. SIGNATURE OF DECEASED</p> | | <p>47. SIGNATURE OF WITNESSES</p> | | <p>48. SIGNATURE OF PHYSICIAN</p> | | <p>49. SIGNATURE OF CLERK</p> | | <p>50. SIGNATURE OF REGISTRAR</p> | |
| <p>51. SIGNATURE OF DECEASED</p> | | <p>52. SIGNATURE OF WITNESSES</p> | | <p>53. SIGNATURE OF PHYSICIAN</p> | | <p>54. SIGNATURE OF CLERK</p> | | <p>55. SIGNATURE OF REGISTRAR</p> | |
| <p>56. SIGNATURE OF DECEASED</p> | | <p>57. SIGNATURE OF WITNESSES</p> | | <p>58. SIGNATURE OF PHYSICIAN</p> | | <p>59. SIGNATURE OF CLERK</p> | | <p>60. SIGNATURE OF REGISTRAR</p> | |
| <p>61. SIGNATURE OF DECEASED</p> | | <p>62. SIGNATURE OF WITNESSES</p> | | <p>63. SIGNATURE OF PHYSICIAN</p> | | <p>64. SIGNATURE OF CLERK</p> | | <p>65. SIGNATURE OF REGISTRAR</p> | |
| <p>66. SIGNATURE OF DECEASED</p> | | <p>67. SIGNATURE OF WITNESSES</p> | | <p>68. SIGNATURE OF PHYSICIAN</p> | | <p>69. SIGNATURE OF CLERK</p> | | <p>70. SIGNATURE OF REGISTRAR</p> | |
| <p>71. SIGNATURE OF DECEASED</p> | | <p>72. SIGNATURE OF WITNESSES</p> | | <p>73. SIGNATURE OF PHYSICIAN</p> | | <p>74. SIGNATURE OF CLERK</p> | | <p>75. SIGNATURE OF REGISTRAR</p> | |
| <p>76. SIGNATURE OF DECEASED</p> | | <p>77. SIGNATURE OF WITNESSES</p> | | <p>78. SIGNATURE OF PHYSICIAN</p> | | <p>79. SIGNATURE OF CLERK</p> | | <p>80. SIGNATURE OF REGISTRAR</p> | |
| <p>81. SIGNATURE OF DECEASED</p> | | <p>82. SIGNATURE OF WITNESSES</p> | | <p>83. SIGNATURE OF PHYSICIAN</p> | | <p>84. SIGNATURE OF CLERK</p> | | <p>85. SIGNATURE OF REGISTRAR</p> | |
| <p>86. SIGNATURE OF DECEASED</p> | | <p>87. SIGNATURE OF WITNESSES</p> | | <p>88. SIGNATURE OF PHYSICIAN</p> | | <p>89. SIGNATURE OF CLERK</p> | | <p>90. SIGNATURE OF REGISTRAR</p> | |
| <p>91. SIGNATURE OF DECEASED</p> | | <p>92. SIGNATURE OF WITNESSES</p> | | <p>93. SIGNATURE OF PHYSICIAN</p> | | <p>94. SIGNATURE OF CLERK</p> | | <p>95. SIGNATURE OF REGISTRAR</p> | |
| <p>96. SIGNATURE OF DECEASED</p> | | <p>97. SIGNATURE OF WITNESSES</p> | | <p>98. SIGNATURE OF PHYSICIAN</p> | | <p>99. SIGNATURE OF CLERK</p> | | <p>100. SIGNATURE OF REGISTRAR</p> | |

BUREAU V. 2

JUL 30 1966

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

9

6789

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg | | | |
| c. LENGTH OF STAY IN 1b 7 mos. | | | | d. STREET ADDRESS 126 Bowery St. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) MINNIE | | First MINNIE | | Middle (UDY) | | Last RODDA | |
| 4. DATE OF DEATH July 9, 1956 | | Month July | | Day 9 | | Year 1956 | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 4-22-1874 | |
| 9. AGE (In years last birthday) 82 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework | | 10b. KIND OF BUSINESS OR INDUSTRY own home | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Frederick Udy | | | | 14. MOTHER'S MAIDEN NAME Hannah Wardell | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. 219-03-9516R | | 17. INFORMANT Mrs. Mildred Myers, Frostburg, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Insufficiency
DUE TO Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Serial
(c) years | | INTERVAL BETWEEN ONSET AND DEATH Serial years | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec 19, 1956 to July 9, 1956 , that I last saw the deceased alive on July 8, 1956 , and that death occurred at 2:45 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE W. M. Lane | | M.D. 167 E Main | | ADDRESS (Street, city or town, state) Frostburg, Md. | | DATE SIGNED July 1956 | |
| PHYSICIAN'S NAME (Type) W. M. Lane MD | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7-11-1956 | | 22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park | | 22d. LOCATION (City, town, or county) (State) Frostburg, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst | | | | ADDRESS Frostburg, Md. | | 24a. REC'D BY REGISTRAR DATE 7-11-56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Mrs. Nancy N. Rose | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06769

Reg. Dist. No.

4

6767

| | | | | | | | |
|---|---|--|---------------------|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>D.O.A. at Memorial Hospital</u> | | | | d. STREET ADDRESS
<u>320 South St</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Martha</u> Middle <u>Jane</u> Last <u>Rollins</u> | | | | 4. DATE OF DEATH
Month <u>July</u> Day <u>23</u> Year <u>19 56</u> | | | |
| 5. SEX
<u>female</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>March 5-1879</u> | 9. AGE (In years last birthday)
<u>77</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Green Spring, W. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Robert B. Crowfis</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Mary C. Seeders</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>none</u> | | 17. INFORMANT
<u>(son) William Rollin, Ridgely, W. Va.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis</u>
(c) <u> </u>
DUE TO
(a), stating the underlying cause lost.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>sudden</u>
<u>several years.</u> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour <u> </u> o. m. <u> </u> p. m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | | (County) | (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>H. V. Deming M.D.</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>July 23-1956</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>July 26, 1956</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Greenmount Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Cumberland, Maryland</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Louis Stein, Inc., Cumberland, Maryland</u> | | | | 24a. REC'D BY REGISTRAR
<u>July 24, 1956</u> | | 24b. REGISTRAR'S SIGNATURE
<u>W. R. Grant, M.D.</u> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 1

JUL 25 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06770

Reg. Dist. No. 4

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY 6768
Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN 1b
76 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
9 W. Second St. | | | | d. STREET ADDRESS
9 W. Second St. | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
Bessie LaCora Roth | | | | 4. DATE OF DEATH
Month Day Year
July 19 19 56 | | | |
| 5. SEX
female | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH
Feb. 15-1880 | | | |
| 9. AGE (In years last birthday)
76 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min.
19 56 | | IF UNDER 24 HRS.
Hours Min.
19 56 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housekeeper | | 10b. KIND OF BUSINESS OR INDUSTRY
Self employed | | 11. BIRTHPLACE (State or foreign country)
Cumberland, Md. | | | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 13. FATHER'S NAME
John M. Roth | | | |
| 14. MOTHER'S MAIDEN NAME
Susan Miller | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
no | | | |
| 16. SOCIAL SECURITY NO.
none | | | | 17. INFORMANT
Address
Sidney D. Phillips, Cumberland, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b) Coronary sclerosis
(c), stating the underlying cause lost. DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH
sudden | | | | | | | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Cumberland, Md. | | | |
| 20f. (City or town)
Cumberland | | 20g. (County)
Allegany | | 20h. (State)
Md. | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE H. V. Deming M.D. M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) H. V. Deming M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER July 20-1956 | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
7-22-56 | | 22c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cem. | | | |
| 22d. LOCATION (City, town, or county)
Cumberland, Md. | | 22e. (State)
Md. | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
James F. Scarpelli | | | | ADDRESS
Cumberland, Md. | | | |
| 24a. REC'D BY REGISTRAR
July 23, 1956 | | 24b. REGISTRAR'S SIGNATURE
W. R. Frantz M.D. | | | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the medical examiner, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

RECEIVED

JUL 24 1956

BUREAU V. S.

REKYLAND STATE DEPT OF HEALTH-BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1573

8702

NAME OF DECEASED
AGE
SEX
RACE
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF EXAMINER
OFFICE OF EXAMINER

DR. W.F.WMS. 6769

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | | | c. LENGTH OF STAY IN 1b 10 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES., | | | | d. STREET ADDRESS R.F.D.#1, Eckhart | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) HENRY W. SCHAUB | | | | 4. DATE OF DEATH JULY 9 1956 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH JULY 30, 1903 | |
| 9. AGE (In years last birthday) 52 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - Kelly Springfield Tire Company | | | | 10b. KIND OF BUSINESS OR INDUSTRY FROSTBURG, MD. | | | |
| 11. BIRTHPLACE (State or foreign country) USA | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME LOUIS SCHAUB | | | | 14. MOTHER'S MAIDEN NAME FANNIE DUNN, Euphem | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 216-07-9086 | | 17. INFORMANT MEMORIAL HOSPITAL Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease
DUE TO 422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cardio
DUE TO 8 mos.
(c) INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Polyneuropathic Kidneys | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year 19
Hour a. m. p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 12-15-55 , 1955, to 7-9-56 , 1956, that I last saw the deceased alive on 7-9-56 , 1956, and that death occurred at 10:15 AM the causes and on the date stated above.
ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 7-9-56 | | | | | | | |
| ACTUAL SIGNATURE Wm. F. Williams | | | | PHYSICIAN'S NAME (Type) Wm. F. Williams, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF July 12, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park | | 22d. LOCATION (City, town, or county) (State) Frostburg, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. L. Durr ADDRESS Frostburg | | | | 24a. REC'D BY REGISTRAR July 11, 1956 | | 24b. REGISTRAR'S SIGNATURE Wm. S. Hantz, M.D. | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

JUL 13 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06772
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 2

| | | | |
|--|---------------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany 6806
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Little Orleans
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 15 Mile Creek, Mudlick Hollow | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Md. b. COUNTY Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Little Orleans
d. STREET ADDRESS R.F.D. Flintstone, Md. e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Richard Middle Clyde Last Shaver | | 4. DATE OF DEATH
Month July Day 1 Year 19 56 | |
| 5. SEX Male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 7-1940 |
| 9. AGE (In years last birthday) 16 yrs. | | IF UNDER 1 YEAR
Months 16 Days 16 | IF UNDER 24 HRS.
Hours 16 Min. 16 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10b. KIND OF BUSINESS OR INDUSTRY School | 11. BIRTHPLACE (State or foreign country) Diana, W. Va. |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Douglas Shaver | |
| 14. MOTHER'S MAIDEN NAME Genevieve Collins | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Star Rott
Wade Wallizer, R.F.D. Flintstone, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia due to drowning
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 929.8
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) sudden | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Bathing, stepped in a deep hole, drown, unable to swim. | |
| 20c. TIME OF INJURY
Month, Day, Year 7-1 19 56
Hour 7:30 p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) 15 Mile creek | | 20f. LOCATION (City, town, or county) (State) Little Orleans Allegany Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE H.V. Deming M.D. | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) H.V. Deming M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER July 2-1956 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF July 5, 1956 | 22c. NAME OF CEMETERY OR CREMATORY Lafayette Memorial Park | 22d. LOCATION (City, town, or county) (State) Brier Hill, Pennsylvania |
| 23. FUNERAL DIRECTOR'S SIGNATURE Skirpin Funeral Service, Brownsville, Pa. | | 24a. REC'D BY REGISTRAR July 5, 1956 | |
| | | 24b. REGISTRAR'S SIGNATURE Thina L. Bender | |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU T. B.

JUL 9 1956

RECEIVED

Within corporate limits

Item 18 Film G200 7-13-56 ams

CERTIFICATE OF DEATH

Reg. Dist. No.

4

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY 6770 MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN 1b
5 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVES. | | | | d. STREET ADDRESS
39 OFFUTT STREET | | | |
| 3. NAME OF DECEASED (Type or print)
First LULU Middle VIRGINIA Last SILVIOUS | | | | 4. DATE OF DEATH
Month JULY Day 2 Year 1956 | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
MAY 22, 1893 | |
| 9. AGE (In years last birthday)
65 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
THREE CHURCHES, W.VA. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
ROBERT ISER | | | | 14. MOTHER'S MAIDEN NAME
AMANDA ELIFRITZ | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
39 Mrs. Naomi Rankin Offutt Street Cumberland, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 600.0 DUE TO anemia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyelonephritis DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 7/2 , 19 56 , to 7/2 , 19 56 , that I last saw the deceased alive on 7/2 , 19 56 , and that death occurred at 9:45 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Leo H. Ley Jr. M.D. | | | | ADDRESS (Street, city or town, state) 456 N. Centre St. Cumberland, Md. | | | |
| DATE SIGNED 7/3/56 | | | | | | | |
| PHYSICIAN'S NAME (Type) LEO H. LEY | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
7/4/56 | | 22c. NAME OF CEMETERY OR CREMATORY
Abe Cemetery | | 22d. LOCATION (City, town, or county) (State)
Mineral County, West Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Maryland | | | | 24a. REC'D BY REGISTRAR
July 3, 1956 | | 24b. REGISTRAR'S SIGNATURE
W. L. Frantz, M.D. | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6771

CERTIFICATE OF DEATH

06774

Reg. Dist. No. 4

| | | | | | |
|---|----------------------------------|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
02 Cumberland, Md. | | | c. LENGTH OF STAY IN 1b
20 days. | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
62 Sacred Heart Hospital | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print)
First Lena Middle F Last Singer | | | 4. DATE OF DEATH
Month July Day 19 Year 19 56 | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 7, 1882 | | 9. AGE (In years last birthday) 74 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housekeeper at Home | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Virginia |
| 13. FATHER'S NAME
William Keyser | | | 14. MOTHER'S MAIDEN NAME
Sarah Virginia Huffman | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Patient's Chart. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 155X DUE TO Blasphemy Carcinoma of the Breast
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Infected Throat DUE TO Unknown
(c) with metastases to liver & ovary | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| | | | 20f. (City or town) | | (County) (State) |
| 21. I certify that I attended the deceased from June 30, 1956 to July 19, 1956 , that I last saw the deceased alive on July 19, 1956 , and that death occurred at M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 41 Greenbelt, Cumberland Md. DATE SIGNED July 20, 1956 | | | | | |
| ACTUAL SIGNATURE B. M. Schindler | | | M.D. 41 Greenbelt | | |
| PHYSICIAN'S NAME (Type) B. M. Schindler, M.D. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
7/21/56 | | 22c. NAME OF CEMETERY OR CREMATORY
Green Hill Cemetery | |
| | | | | 22d. LOCATION (City, town, or county) (State)
Luray, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
H. Lee Silcox | | | ADDRESS
Cumberland, Md. | | |
| | | | 24a. REC'D BY REGISTRAR
DATE July 20, 1956 | | |
| | | | 24b. REGISTRAR'S SIGNATURE
W. H. Frank, M.D. | | |

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06775

6772

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL Hospital | | d. STREET ADDRESS
ALLEGANY INN, BALTIMORE AVE. | |
| 3. NAME OF DECEASED (Type or print)
First CARL Middle F. Last SLEMMER | | 4. DATE OF DEATH
Month JULY Day 26 Year 19 56 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
NOVEMBER 22 1906 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CHEMIST | | 10b. KIND OF BUSINESS OR INDUSTRY
RUBBER INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JOHN SLEMMER | | 14. MOTHER'S MAIDEN NAME
ANNA HETZEL | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
214-07-0456 | |
| 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND, MD. | | Address | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Nephritis & Uremia
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH
26 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Cirrhosis of Liver & Ascaris | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

| | | | |
|---|---|--|--------------------------------------|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. _____ p. m. _____ 19 _____ | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 5/15/56 , 19____, to 7/26/56 , 19____, that I last saw the deceased alive on 7/26/56 , 19____, and that death occurred at 6:58 P. M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Richard J. Williams M.D. | | DATE SIGNED
7/27/56 | |
| PHYSICIAN'S NAME (Type)
RICHARD J. WILLIAMS M.D. | | ADDRESS (Street, city or town, state)
Cumberland Md | |

| | | | |
|--|--|---|---|
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
July 28 1956 | 22c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | 22d. LOCATION (City, town, or county) (State)
Cumberland Md |
| 23. FUNERAL DIRECTOR'S SIGNATURE
W. R. Frantz | | 24. REC'D BY REGISTRAR
W. R. Frantz, M.D. | |
| ADDRESS
Cumberland, Md. | | DATE
July 28, 1956 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0735

| | | | | | | | | | | | | | | | |
|-------------------------------------|--|-----------------------------|--|--|--|------------------------------------|--|--------------------------------------|--|-----------------------|--|--|--|-------------------------------|--|
| NAME OF DECEASED
JAMES H. HARRIS | | AGE
65 YRS | | SEX
MALE | | RACE
WHITE | | EDUCATION
HIGH SCHOOL | | OCCUPATION
RETIRED | | MARRIAGE
MARRIED | | RELIGION
METHODIST | |
| DATE OF DEATH
JULY 28 1956 | | PLACE OF DEATH
HOME | | CITY
BALTIMORE | | COUNTY
BALTIMORE | | STATE
MARYLAND | | ZIP CODE
21201 | | HOSPITAL
NONE | | PHYSICIAN
DR. J. H. HARRIS | |
| CAUSE OF DEATH
HEART DISEASE | | MANNER OF DEATH
NATURAL | | IMMEDIATE CAUSE
CORONARY THROMBOSIS | | INTERMEDIATE CAUSE
HYPERTENSION | | UNDERLYING CAUSE
ARTERIOSCLEROSIS | | OTHER CAUSES
NONE | | SIGNS AND SYMPTOMS
PAIN IN CHEST, SHORTNESS OF BREATH | | TREATMENT
MEDICATION | |
| DATE OF BIRTH
JULY 15 1891 | | PLACE OF BIRTH
BALTIMORE | | CITY
BALTIMORE | | COUNTY
BALTIMORE | | STATE
MARYLAND | | ZIP CODE
21201 | | HOSPITAL
NONE | | PHYSICIAN
DR. J. H. HARRIS | |
| DATE OF DEATH
JULY 28 1956 | | PLACE OF DEATH
HOME | | CITY
BALTIMORE | | COUNTY
BALTIMORE | | STATE
MARYLAND | | ZIP CODE
21201 | | HOSPITAL
NONE | | PHYSICIAN
DR. J. H. HARRIS | |

BUREAU V. 3

JUL 31 1956

RECEIVED

6773

CERTIFICATE OF DEATH

Reg. Dist. No.

4

| | | | |
|---|-----------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND, MD | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND, MD. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
27 ARCH STREET | | d. STREET ADDRESS
27 ARCH ST. | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
JAN JAMES L. SMITH SMITH | | 4. DATE OF DEATH
Month Day Year
7-28-56 19 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH
AUG. 11, 1888 - 67 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED CONDUCTOR | | 10b. KIND OF BUSINESS OR INDUSTRY
RAILROAD | 9. AGE (In years last birthday)
67 yrs. |
| 11. BIRTHPLACE (State or foreign country)
LEON, W. VA. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
CLARK SMITH | | 14. MOTHER'S MAIDEN NAME
ELLEN HARRIS | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
705-09-3645 | |
| 17. INFORMANT
GLADUS AMITH CUMBERLAND, MD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 422.1 Acute Myocardial Failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio-
DUE TO Vascular Disease
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Arteriosclerosis
INTERVAL BETWEEN ONSET AND DEATH
Immediate
5-yr. | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from May 19, to July 28, 1956, that I last saw the deceased alive on July 19, 1956, and that death occurred at 7:45 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
57 GREENE ST 7/28/56
ACTUAL SIGNATURE Saville G WEISMAN M.D. CUMBERLAND MD
PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 22b. DATE THEREOF
8-1-56 | 22c. NAME OF CEMETERY OR CREMATORY
GOSHEN CEM. | 22d. LOCATION (City, town, or county) (State)
RICHMOND, IND. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
James T. Scarpelli, Cumberland, Md. | | 24. REC'D BY REGISTRAR
July 30, 1956 | |
| 24b. REGISTRAR'S SIGNATURE
W.R. Hantz, M.D. | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

RECEIVED
JUL 31 1956
BUREAU V. S.

| | | | | | | | | | | | |
|------------------------|--|-------------|--|----------|--|-------------------|--|---------------|--|----------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES J. WOOD | | 45 | | M | | W | | JAN 1 1911 | | NEW YORK | |
| MARRIAGE | | DATE | | PLACE | | NAME OF SPOUSE | | DATE OF DEATH | | PLACE OF DEATH | |
| MARRIED | | JAN 1 1935 | | NEW YORK | | JANE J. WOOD | | JUL 28 1956 | | NEW YORK | |
| OCCUPATION | | DATE | | PLACE | | NAME OF EMPLOYER | | DATE OF DEATH | | PLACE OF DEATH | |
| CLOCK REPAIRER | | JUL 28 1956 | | NEW YORK | | JAMES J. WOOD | | JUL 28 1956 | | NEW YORK | |
| CAUSE OF DEATH | | DATE | | PLACE | | NAME OF PHYSICIAN | | DATE OF DEATH | | PLACE OF DEATH | |
| HEART DISEASE | | JUL 28 1956 | | NEW YORK | | JAMES J. WOOD | | JUL 28 1956 | | NEW YORK | |
| MANNER OF DEATH | | DATE | | PLACE | | NAME OF PHYSICIAN | | DATE OF DEATH | | PLACE OF DEATH | |
| NATURAL | | JUL 28 1956 | | NEW YORK | | JAMES J. WOOD | | JUL 28 1956 | | NEW YORK | |
| SIGNATURE OF DECEASED | | DATE | | PLACE | | NAME OF PHYSICIAN | | DATE OF DEATH | | PLACE OF DEATH | |
| JAMES J. WOOD | | JUL 28 1956 | | NEW YORK | | JAMES J. WOOD | | JUL 28 1956 | | NEW YORK | |
| SIGNATURE OF WITNESS | | DATE | | PLACE | | NAME OF PHYSICIAN | | DATE OF DEATH | | PLACE OF DEATH | |
| JANE J. WOOD | | JUL 28 1956 | | NEW YORK | | JAMES J. WOOD | | JUL 28 1956 | | NEW YORK | |
| SIGNATURE OF PHYSICIAN | | DATE | | PLACE | | NAME OF PHYSICIAN | | DATE OF DEATH | | PLACE OF DEATH | |
| JAMES J. WOOD | | JUL 28 1956 | | NEW YORK | | JAMES J. WOOD | | JUL 28 1956 | | NEW YORK | |

1
Within corporate limits

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06777

Reg. Dist. No.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE W. Va b. COUNTY Mineral | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wiley Ford | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.C.A. at Memorial Hospital | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print)
First Andrew Middle Daniel Last Snyder | | 4. DATE OF DEATH
Month July Day 23 Year 19 56 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH Feb. 20-1888 | 9. AGE (In years last birthday) 68 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant | | 10b. KIND OF BUSINESS OR INDUSTRY Confectionary | 11. BIRTHPLACE (State or foreign country) Cumberland, Md. |
| 13. FATHER'S NAME Andrew Henry Snyder | | 14. MOTHER'S MAIDEN NAME Catherine Glos | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 217-05-4187 | |
| 17. INFORMANT (son) Robert E. Snyder, LaVale, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Coronary sclerosis
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH sudden
8 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) | | (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE H. V. Downing M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) H. V. Downing M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED July 23-1956 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF July 25, 1956 | 22c. NAME OF CEMETERY OR CREMATORY Sts. Peter & Paul Cemetery | 22d. LOCATION (City, town, or county) (State) Cumberland, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Maryland. | | 24a. REC'D BY REGISTRAR July 24, 1956 | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE W. R. Frantz M.D. | |

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU Y. 1

JUL 25 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6775
CERTIFICATE OF DEATH

06778

Reg. Dist. No.

4

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE PENNSYLVANIA b. COUNTY BEDFORD | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN 1b
7 DAYS | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BREEZEWOOD | | d. STREET ADDRESS
75 X - 3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVES., | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First MARIAN Middle W. Last SNYDER | | 4. DATE OF DEATH
Month JULY Day 16 Year 19 56 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
APRIL 4, 1892 |
| 9. AGE (In years last birthday)
64 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 11. BIRTHPLACE (State or foreign country)
PENNA. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
FRANK WOY | | 14. MOTHER'S MAIDEN NAME
MARY ZINN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Memorial Hospital | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Carcinomatosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Breast
DUE TO
(c) 10 years. | | INTERVAL BETWEEN ONSET AND DEATH
10 years. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 9 July, 1956 , to 16 July, 1956 , that I last saw the deceased alive on 16 July, 1956 , and that death occurred at 12:05 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE W. H. Van Ormer | | ADDRESS (Street, city or town, state) Cumberland, Maryland | |
| PHYSICIAN'S NAME (Type) W. H. VAN ORMER | | DATE SIGNED 16 July 56 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
July 19, 1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Harvard Cemetery | | 22d. LOCATION (City, town, or county) (State)
Somerset, Somerset Co., Penna. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Walter S. Hoffman | | ADDRESS
138 E. Main St. Somerset, Pa. | |
| 24a. REC'D BY REGISTRAR
DATE July 17, 1956 | | 24b. REGISTRAR'S SIGNATURE
W. R. Frantz, M.D. | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

CERTIFICATE OF DEATH

BUREAU V. S.

JUL 25 1956

RECEIVED

DR. WEISMAN

6776

CERTIFICATE OF DEATH

06780

Reg. Dist. No.

4

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. PLACE OF DEATH
o. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN 1b
95 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL | | | | d. STREET ADDRESS
523 WASHINGTON ST. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First EMMA Middle C Last STINGLEY | | | | 4. DATE OF DEATH
Month JULY Day 13 Year 19 56 | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
OCT. 24, 1896 | |
| 9. AGE (In years last birthday)
79 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
MD. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
THOMAS F. MYERS | | | | 14. MOTHER'S MAIDEN NAME
EMILY SUTER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Address
MEMORIAL HOSPITAL - WARWICK & MEMORIAL AVES. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF HEPATIC FLEXURE OF COLON WITH METASTASES TO LIVER
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) AND ANEMIA DUE TO ABOVE
(c) AND HEART FAILURE DUE TO ANEMIA | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
12 mos
3 mos
3 mos |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 9, 1956 , to July 13, 1956 , that I last saw the deceased alive on July 13, 1956 , and that death occurred at 7:40 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
A. Olevinskae | | | | ADDRESS (Street, city or town, state)
596 REENE ST CUMBERLAND MD | | DATE SIGNED
7/13/56 | |
| PHYSICIAN'S NAME (Type)
S. G. WEISMAN, MD | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
7/16/56 | | 22c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cem. | | 22d. LOCATION (City, town, or county) (State)
Cumberland Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Louis Stein Inc | | | | ADDRESS
Cum. Md | | 24b. REGISTRAR'S SIGNATURE
W. R. Frank, M.D. | |
| 24a. REC'D BY REGISTRAR
DATE July 16, 1956 | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1214

BUREAU V. 3

18 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5, should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6791 CERTIFICATE OF DEATH

06781

Reg. Dist. No. 6

| | | | | | |
|--|---|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Westernport | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Rooker Nursing Home | | | d. STREET ADDRESS
215 Virginia Ave. | | |
| 3. NAME OF DECEASED (Type or print)
Arthur Andrew Thomas | | | 4. DATE OF DEATH
Month July Day 28 Year 1956 | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 29 1887 | | 9. AGE (In years last birthday)
69 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY
Building | 11. BIRTHPLACE (State or foreign country)
Kansas | | 12. CITIZEN OF WHAT COUNTRY?
U.S. |
| 13. FATHER'S NAME
Andrew Thomas | | | 14. MOTHER'S MAIDEN NAME
M. Alice Wymore | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
(If yes, give war or dates of service) | 17. INFORMANT
James Thomas Address Cumberland | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis
332x DUE TO
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. 260x (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 week |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that I attended the deceased from July 23, 1956 , to July 28, 1956 , that I last saw the deceased alive on July 28, 1956 , and that death occurred at 10 A. M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state)
DATE SIGNED 7-30-56 | | | | | |
| ACTUAL SIGNATURE
James H. Wolverton Jr. | | M.D. Richard W. U. | | | |
| PHYSICIAN'S NAME (Type)
James H. Wolverton Jr. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
July 30, 1956 | 22c. NAME OF CEMETERY OR CREMATORY
Levels W. Va. | 22d. LOCATION (City, town, or county) (State)
Levels W. Va. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
James Scarpelli | | ADDRESS
Cumberland Md. | | 24a. REC'D BY REGISTRAR
DATE 7-30-56 | 24b. REGISTRAR'S SIGNATURE
John C. Kelly |

CERTIFICATE OF DEATH

1956

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|-------------------------------------|--|
| NAME OF DECEASED
JOHN J. BROWN | | AGE
45 | | SEX
MALE | | RACE
WHITE | | DATE OF BIRTH
11-15-11 | | PLACE OF BIRTH
NEW YORK | |
| MARRIAGE
1935 | | OCCUPATION
LABORER | | CAUSE OF DEATH
HEART DISEASE | | MANNER OF DEATH
NATURAL | | DATE OF DEATH
7-1-56 | | PLACE OF DEATH
NEW YORK | |
| FATHER'S NAME
JOHN J. BROWN | | MOTHER'S NAME
MARY J. BROWN | | DECEASED'S RESIDENCE
1234 5TH AVE. NEW YORK | | DECEASED'S OCCUPATION
LABORER | | DECEASED'S STATUS
MARRIED | | DECEASED'S SEX
MALE | |
| FATHER'S OCCUPATION
LABORER | | MOTHER'S OCCUPATION
HOUSEWIFE | | DECEASED'S STATUS
MARRIED | | DECEASED'S SEX
MALE | | DECEASED'S RACE
WHITE | | DECEASED'S AGE
45 | |
| FATHER'S DATE OF BIRTH
1-1-1890 | | MOTHER'S DATE OF BIRTH
2-1-1895 | | DECEASED'S DATE OF BIRTH
11-15-11 | | DECEASED'S PLACE OF BIRTH
NEW YORK | | DECEASED'S OCCUPATION
LABORER | | DECEASED'S STATUS
MARRIED | |
| FATHER'S PLACE OF BIRTH
NEW YORK | | MOTHER'S PLACE OF BIRTH
NEW YORK | | DECEASED'S PLACE OF BIRTH
NEW YORK | | DECEASED'S OCCUPATION
LABORER | | DECEASED'S STATUS
MARRIED | | DECEASED'S SEX
MALE | |
| FATHER'S RACE
WHITE | | MOTHER'S RACE
WHITE | | DECEASED'S RACE
WHITE | | DECEASED'S AGE
45 | | DECEASED'S SEX
MALE | | DECEASED'S STATUS
MARRIED | |
| FATHER'S AGE
66 | | MOTHER'S AGE
61 | | DECEASED'S AGE
45 | | DECEASED'S SEX
MALE | | DECEASED'S STATUS
MARRIED | | DECEASED'S RACE
WHITE | |
| FATHER'S DATE OF DEATH
1-1-1950 | | MOTHER'S DATE OF DEATH
2-1-1955 | | DECEASED'S DATE OF DEATH
7-1-56 | | DECEASED'S PLACE OF DEATH
NEW YORK | | DECEASED'S OCCUPATION
LABORER | | DECEASED'S STATUS
MARRIED | |
| FATHER'S PLACE OF DEATH
NEW YORK | | MOTHER'S PLACE OF DEATH
NEW YORK | | DECEASED'S PLACE OF DEATH
NEW YORK | | DECEASED'S OCCUPATION
LABORER | | DECEASED'S STATUS
MARRIED | | DECEASED'S SEX
MALE | |
| FATHER'S RACE
WHITE | | MOTHER'S RACE
WHITE | | DECEASED'S RACE
WHITE | | DECEASED'S AGE
45 | | DECEASED'S SEX
MALE | | DECEASED'S STATUS
MARRIED | |
| FATHER'S AGE
66 | | MOTHER'S AGE
61 | | DECEASED'S AGE
45 | | DECEASED'S SEX
MALE | | DECEASED'S STATUS
MARRIED | | DECEASED'S RACE
WHITE | |

BUREAU VI

JUL 31 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06782

Reg. Dist. No. 4

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>
c. LENGTH OF STAY IN lb <u>90 yrs.</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>
d. STREET ADDRESS <u>405 Pulaski St.</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>William</u> Middle <u>E</u> Last <u>Thompson</u>
4. DATE OF DEATH
Month <u>July</u> Day <u>6</u> Year <u>1956</u> | | | | 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug. 8-1865</u>
9. AGE (In years last birthday) <u>90</u> yrs. IF UNDER 1 YEAR
Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.
Hours <u>0</u> Min. <u>0</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - car inspector</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>B&O.R.Ry.</u>
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | 13. FATHER'S NAME <u>Manuel Thompson</u>
14. MOTHER'S MAIDEN NAME <u>Ella Frost</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. <u>none</u>
17. INFORMANT <u>Sacred Heart Hospital records.</u> Address | | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Intrathoracic hemorrhage due to a crushed chest.</u>
DUE TO (b) <u>also had a rupture of the liver & spleen.</u>
DUE TO (c) <u>a fall.</u>
INTERVAL BETWEEN ONSET AND DEATH <u>1.1/4 hrs.</u>
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY (or CONTRIBUTING) CAUSE OF DEATH.
<u>Blind, fell over bannister from second floor porch.</u> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
<u>4.12</u> Hour <u>7-6</u> p.m. <u>1956</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | | | 20f. (City or town) <u>Cumberland</u> (County) <u>Allegany</u> (State) <u>Md.</u> | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>July 7-1956</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>7/9/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cem.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Maryland</u> | | | | 24a. REC'D BY REGISTRAR <u>July 9, 1956</u> | | 24b. REGISTRAR'S SIGNATURE <u>C. R. Hantz, M.D.</u> | |

1. William corporate limits

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please see-
 cution certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be
 forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation,
 or removal.

STATE OF NEW YORK
DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

BUREAU V. S.

JUL 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6778

CERTIFICATE OF DEATH

06783

Reg. Dist. No. 4

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegheny</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> | | | | c. LENGTH OF STAY IN 1b <u>10 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u> | | | | d. STREET ADDRESS <u>606 Shriver Ave</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>MAY</u> Last <u>Thrush</u> | | | | 4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1956</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>April 12, 1871</u> | |
| 9. AGE (In years last birthday) <u>85</u> yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Dwn Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>W. Va.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Charles Dyche</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Nancy Dawson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>George Thrush, Cumberland, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of ascending colon</u>
<u>153X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with Pulmonary Metastases</u>
DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>7-17</u> , 19 <u>56</u> , to <u>7-26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7-26</u> , 19 <u>56</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>441 N. Center St.</u> DATE SIGNED <u>7-28-56</u> | | | | | | | |
| ACTUAL SIGNATURE <u>William R. James</u> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>William R. James-M.D.</u> <u>Cumberland</u> <u>Md.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>July 29, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u> | | 22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George, Cumberland, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>July 29, 1956</u> | | 24b. REGISTRAR'S SIGNATURE <u>W.R. Frank, M.D.</u> | |

BUREAU V.

JUL 31 1956

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 18 Film G200 7-13-56 ams

Reg. Dist. No.

4

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany 6779 MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. LENGTH OF STAY IN 1b 11 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Louisa Middle Trimble Last Trimble | | 4. DATE OF DEATH Month July Day 3 Year 19 56 | |
| 5. SEX Female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 23-1892 |
| 9. AGE (In years last birthday) 64 yrs. | | IF UNDER 1 YEAR Months 6 Days 4 | IF UNDER 24 HRS. Hours 3 Min. 56 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic & cook | | 10b. KIND OF BUSINESS OR INDUSTRY P.J. Arendes | |
| 11. BIRTHPLACE (State or foreign country) Conn. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles C. Johnson | | 14. MOTHER'S MAIDEN NAME Phyllis Hayes | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 218-30-2309 | |
| 17. INFORMANT Address Sacred Heart Hospital records. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia
DUE TO
Conditions, if any, which gave rise to immediate cause (b) Acute nephritis
(a), stating the underlying cause lost. (c) 590x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Impacted fracture of right femur.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. 590x | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Putting trash in garbage can, fell on concrete porch. | |
| 20c. TIME OF INJURY Month, Day, Year 11 - 6-23 19 56 | 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Back porch | 20f. (City or town) (County) (State) Cumberland, Allegany Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE H.V. Deming M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) H.V. Deming M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> July 3-1956 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF July 6, 1956 | 22c. NAME OF CEMETERY OR CREMATORY Woodlawn Burial Park | 22d. LOCATION (City, town, or county) (State) Cumberland, Maryland. |
| 23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland. | | 24a. REC'D BY REGISTRAR July 5, 1956 | |
| | | 24b. REGISTRAR'S SIGNATURE H.V. Deming M.D. | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 6 1956

RECEIVED

RECEIVED JUL 10 1956

6780

CERTIFICATE OF DEATH

06785/4

Reg. Dist. No.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | |
| c. LENGTH OF STAY IN 1b
9 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL | | d. STREET ADDRESS
8 HARRISON STREET | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First VERNA Middle TROUT Last | | 4. DATE OF DEATH
Month JULY Day 19 Year 1956 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
AUGUST 23, 1881 |
| 9. AGE (In years last birthday)
74 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 11. BIRTHPLACE (State or foreign country)
NEEDMORE, PENNA. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
JOHN SNYDER | | 14. MOTHER'S MAIDEN NAME
JANE GORDEN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Mrs. Helen Hayhurst, Cumberland, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 602x Thraemia
DUE TO (b) Unilateral Calculus R.
DUE TO (c) Chronic Myocarditis | | INTERVAL BETWEEN ONSET AND DEATH
12 days
2 yrs
2 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 5, 1956 to July 19, 1956 that I last saw the deceased alive on July 19, 1956 and that death occurred at 4:02P M. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) DATE SIGNED 7/20/56 | |
| ACTUAL SIGNATURE Clay Durrett M.D. Cumberland | | | |
| PHYSICIAN'S NAME (Type) DR CLAY DURRETT | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
July 22, 1956 | 22c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | 22d. LOCATION (City, town, or county) (State)
Cumberland, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles L. George, Cumberland, Md. | | 24a. REC'D BY REGISTRAR
July 22, 1956 | |
| | | 24b. REGISTRAR'S SIGNATURE
A.R. Frantz, M.D. | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, or other person authorized by law, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06786

6827

CERTIFICATE OF DEATH

Reg. Dist. No.

6

| | | | | | |
|--|----------------------------------|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Moscow, Md.</u> | | c. LENGTH OF STAY IN 1b
<u>4 YRS.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Moscow, Md.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
<u>Moscow, Md.</u> | | | d. STREET ADDRESS
<u>Moscow, Md.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First <u>Frank</u> Middle <u>Louis</u> Last <u>Wilt</u> | | | 4. DATE OF DEATH
July <u>30</u> Day <u>30</u> Year <u>56</u> | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Dec. 29, 1887</u> | 9. AGE (In years lost in day) yrs.
<u>68</u> | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>W.Va. Paper Mill</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | | | | | |
| 13. FATHER'S NAME
<u>Frank W. Wilt</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Not Known</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u> </u> | | 17. INFORMANT
<u>Louis Wilt</u> Address <u>Winchester, Virginia</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>443X Congestive Heart failure</u>
DUE TO (b) <u>Essential Hypertension</u>
DUE TO (c) <u>Atherosclerosis</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Several yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED
White <input type="checkbox"/> Not white <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <u>July 19, 1956</u> to <u>July 30, 1956</u> , that I last saw the deceased alive on <u>July 28, 1956</u> , and that death occurred at <u>7:15 p.m.</u> from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE <u>Leslie R. Miles, Jr., M.D.</u> | | | | ADDRESS (Street, city or town, state) <u>Sonscoming, Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>Leslie R. Miles, Jr., M.D.</u> | | | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>August 2, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Morrison Cem.</u> | |
| 22d. LOCATION (City, town, or county)
<u>Allegany Co. Md.</u> | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>E. J. Boal</u> | | | ADDRESS | | |
| 24a. REC'D BY REGISTRAR
DATE <u>8-5-56</u> | | 24b. REGISTRAR'S SIGNATURE
<u>John C. Kelly</u> | | | |

CERTIFICATE OF DEATH

BUREAU V. S.

AUG 8 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6808

Reg. Dist. No. 06787

| | | | | | | | |
|--|----------------------------------|--|--------------------------------------|---|---|--|------------------|
| 1. PLACE OF DEATH
o. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Mt. Savage-rural | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Mt. Savage-rural | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print)
First WILLIAM Middle M. Last WINEBRENNER | | | | 4. DATE OF DEATH
Month July Day 7 Year 19 56 | | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3-31-1877 | | 9. AGE (In years last birthday)
79 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
retired miner | | 10b. KIND OF BUSINESS OR INDUSTRY
coal mines | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
James H. Winebrenner | | | | 14. MOTHER'S MAIDEN NAME
Susanna Logsdon | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
213-01-4667A | | 17. INFORMANT Address
Mrs. Grahame Bowers, Mt. Savage, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myocardiosis
422.2 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 1954 , to July 7 1956 , that I last saw the deceased alive on July 6 1956 , and that death occurred at 5:4 M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Hyndman Pa DATE SIGNED 7/8/56 | | | | | | | |
| ACTUAL SIGNATURE John A. Topper | | M.D. Hyndman Pa | | | | | |
| PHYSICIAN'S NAME (Type) John A. Topper | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
7-9-1956 | | 22c. NAME OF CEMETERY OR CREMATORY
Porter Cemetery | | 22d. LOCATION (City, town, or county) (State)
Eckhart, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. R. Durst, | | | | ADDRESS
Frostburg, Md. | | 24a. REC'D BY REGISTRAR
DATE 7-10-56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Veronica M. Deimitt | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--|---------------------------------|--|--|--|--|--|-----------------------------------|--|----------------------------|--|
| NAME OF DECEASED
JAMES H. HARRINGTON | | AGE
45 | | SEX
Male | | RACE
White | | DATE OF BIRTH
1910 | | PLACE OF BIRTH
Maryland | |
| MANNER OF DEATH
Natural | | CAUSE OF DEATH
Heart Disease | | IMMEDIATE CAUSE
Myocardial Infarction | | DISEASE OR INJURY
Coronary Artery Disease | | PERIOD OF ILLNESS
Several days | | PLACE OF DEATH
Home | |
| DATE OF DEATH
July 15, 1956 | | TIME OF DEATH
10:00 AM | | PLACE OF DEATH
Home | | NAME OF PHYSICIAN
Dr. J. H. Smith | | NAME OF HOSPITAL
None | | NAME OF NURSE
None | |
| NAME OF DECEASED
JAMES H. HARRINGTON | | AGE
45 | | SEX
Male | | RACE
White | | DATE OF BIRTH
1910 | | PLACE OF BIRTH
Maryland | |
| MANNER OF DEATH
Natural | | CAUSE OF DEATH
Heart Disease | | IMMEDIATE CAUSE
Myocardial Infarction | | DISEASE OR INJURY
Coronary Artery Disease | | PERIOD OF ILLNESS
Several days | | PLACE OF DEATH
Home | |
| DATE OF DEATH
July 15, 1956 | | TIME OF DEATH
10:00 AM | | PLACE OF DEATH
Home | | NAME OF PHYSICIAN
Dr. J. H. Smith | | NAME OF HOSPITAL
None | | NAME OF NURSE
None | |

DECEASED'S SIGNATURE: *James H. Harrington*

PHYSICIAN'S SIGNATURE: *Dr. J. H. Smith*

DATE: JUL 16 1956

BUREAU V. 8

JUL 16 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6781

CERTIFICATE OF DEATH

06788

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|---|---|
| 1. PLACE OF DEATH
o. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | | c. LENGTH OF STAY IN 1b
<u>9 hrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>near Cumberland rural</u> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Sacred Heart Hospital</u> | | | | d. STREET ADDRESS
<u>Pt. # 3 Bedford Rd.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>William</u> Middle <u>J.</u> Last <u>Winfield</u> | | | | 4. DATE OF DEATH
Month <u>7</u> Day <u>27</u> Year <u>19 56</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>1/5/85</u> | |
| 9. AGE (In years last birthday)
<u>71</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired Carman</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Md. Cumberland,</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>John Winfield</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Catharine Liobel</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>705-05-4596</u> | | 17. INFORMANT
Address <u>chart Mary Winfield Bedford Rd.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
DUE TO <u>Cerebral Arteriosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Cerebral Arteriosclerosis</u>
(c) <u>Chronic Nephritis</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>12 hrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Chronic Nephritis</u> | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. — 19
p. m. — | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>2/4/54</u> , 19 <u>54</u> , to <u>7/27/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/26/56</u> , 19 <u>56</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<u>Richard J. Williams</u> | | | | ADDRESS (Street, city or town, State)
<u>Cumberland, Md.</u> | | DATE SIGNED
<u>7/27/56</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>7-30-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>St. Peters & Paul Cem</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Cumberland, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>James F. Scarpelli</u> | | | | ADDRESS
<u>Cumberland, Md.</u> | | 24a. REC'D BY REGISTRAR
<u>July 30, 1956</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>W. L. Frank, M.D.</u> | | | |

BUREAU V. 3.

JUL 31 1956

RECEIVED